

IN THE CIRCUIT COURT OF THE
FIFTEENTH JUDICIAL CIRCUIT, IN AND
FOR PALM BEACH COUNTY, FLORIDA

CASE NO. 2012CA020960XXXXMBAA

DOMINIC J. SHELTON, a minor, by and through
his parents and natural guardians, HEATHER
MCCANTS and BILLY SHELTON, and
HEATHER MCCANTS and BILLY SHELTON,
individually,

Plaintiffs,

v.

BERTO LOPEZ, M.D., LISA M. SANCHES,
M.D., OB GYN SPECIALISTS OF THE PALM
BEACHES, P.A., KERRY S. LANE, M.D.,
ANESTHESIA AND CRITICAL CARE
SPECIALISTS OF PALM BEACH, P.A., TENET
ST. MARY'S INC., d/b/a ST. MARY'S MEDICAL
CENTER, a Florida corporation,

Defendants.

NOTICE OF FILING DEPOSITION TRANSCRIPTS OF BERTO LOPEZ, M.D.

Plaintiffs, DOMINIC J. SHELTON, a minor, by and through his parents and natural
guardians, HEATHER MCCANTS and BILLY SHELTON, and HEATHER MCCANTS and
BILLY SHELTON, individually, by and through undersigned counsel, hereby gives notice of
filing the following deposition transcripts:

1. Berto Lopez, M.D., Volume I, taken on August 9, 2013; and
2. Berto Lopez, M.D., Volume I, taken on October 17, 2013.

I HEREBY CERTIFY that a true copy of the foregoing was furnished to all counsel on the attached service list, by email, on May 20, 2015.

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Case No. 2012CA020960XXXXMBAA

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IN THE FIFTEENTH JUDICIAL CIRCUIT COURT
IN AND FOR PALM BEACH COUNTY, FLORIDA
CASE NO. 2012 CA 020960 XXXX MBAA

DOMINIC J. SHELTON, a minor, by
and through his parents and
natural guardians, HEATHER
MCCANTS and BILLY SHELTON, and
HEATHER MCCANTS and BILL
SHELTON, individually,

Plaintiffs,

vs.

BERTO LOPEZ, M.D., LISA M.
SANCHES, M.D., OBGYN SPECIALISTS
OF THE PALM BEACHES, P.A., KERRY
S. LANE, M.D., ANESTHESIA AND
CRITICAL CARE SPECIALISTS OF
PALM BEACH, P.A., TENET ST.
MARY'S INC., D/B/A ST. MARY'S
MEDICAL CENTER, a Florida
corporation,

Defendants.

DEPOSITION OF BERTO LOPEZ, M.D.
(VIDEOTAPED)
VOLUME I

FRIDAY, AUGUST 9, 2013
2:09 p.m. - 6:18 p.m.

515 NORTH FLAGLER DRIVE #1701
WEST PALM BEACH, FLORIDA

Reported By:
Eleanor M. Evensen, RPR
Notary Public, State of Florida
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I N D E X

- - -

WITNESS: DIRECT CROSS REDIRECT RECROSS

BERTO LOPEZ, M.D.

BY: MR. SILVA 5

- - -

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Deposition taken before ELEANOR M.
EVENSEN, Registered Professional Reporter and Notary
Public in and for the State of Florida at Large, in
the above cause.

- - -

THE VIDEOGRAPHER: We are now on the video
record. This is videotape number 1 to the
videotaped deposition of Dr. Berto Lopez in the
matter of Dominick J. Shelton, a minor, by and
through his parents and natural guardians,
Heather McCants and Billy Shelton, and Heather
McCants and Billy Shelton, individually,
plaintiffs, versus Berto Lopez, M.D., et. al.

The case is being heard in the Circuit Court
of the 15th Judicial Circuit in and for Palm
Beach County, Florida.

Today's date is August 9, 2013, and the time
on the video monitor is 2:09 p.m. My name is
Anthony Barbaro and I am the videographer. The
court reporter is Eleanor Evensen.

Counsel, would you please announce your
appearances and affiliations and the witness will
be sworn.

1 MS. WIDLANSKY: Ariel Widlansky on behalf of
2 Dr. Berto Lopez.

3 MR. MITTELMARK: Mike Mittelman on behalf of
4 St. Mary's Medical Center.

5 MR. BLOOM: Josh Bloom on behalf of
6 Dr. Sanches, and OBGYN Specialists of the Palm
7 Beaches.

8 MR. PUYA: Keith Puya for Dr. Kerry Lane.

9 MR. SILVA: Paul Silva for the plaintiffs.

10 Thereupon,

11 BERTO LOPEZ, M.D.

12 having been first duly sworn or affirmed, was examined
13 and testified as follows:

14 THE WITNESS: I do.

15 DIRECT EXAMINATION

16 BY MR. SILVA:

17 Q. Give us your full name for the record.

18 A. Berto Lopez.

19 Q. And do you have any licenses in the State of
20 Florida?

21 A. Yes, I'm licensed to practice medicine.

22 Q. I notice that you are wearing some scrubs and a
23 white coat with you today.

24 A. Yes.

25 Q. Okay. Did you -- tell me about your day today.

1 Have you been in the operating room?

2 A. I did a -- I've done a couple of -- I've done
3 I think two vaginal deliveries today, and I have one
4 patient that's in labor at St. Mary's.

5 Q. Have you changed your scrubs since you did your
6 vaginal deliveries?

7 A. Yes, I have actually. I took a shower and
8 changed.

9 Q. And are you still on the job?

10 A. Yes. When I leave here I have go to back to
11 St. Mary's because I have a patient that's in labor.

12 Q. Is there any reason that you didn't wear a suit
13 today?

14 A. I don't wear suits, I generally live in
15 scrubs.

16 Q. You don't wear suits when you see patients in
17 the office?

18 A. No, I don't, I wear scrubs. And in fact, I
19 wore -- this is what I wore except the scrubs were
20 changed at lunchtime when I took a shower.

21 Q. Now, I notice that you also have a white coat
22 on.

23 Can you zoom in on that? You can start with the
24 right side name and specialty, and then the left side,
25 St. Mary's.

1 THE VIDEOGRAPHER: Okay.

2 MR. SILVA: Thank you.

3 BY MR. SILVA:

4 Q. You are wearing a white coat and it has on the
5 right side an emblem; is that St. Mary's emblem, the
6 cross?

7 A. Yes.

8 Q. And then it says: St. Mary's Medical Center?

9 A. Yes.

10 Q. And on the left side it says: Berto Lopez,
11 M.D., yourself obviously, and obstetrics and gynecology,
12 right?

13 A. Yes.

14 Q. Who was that jacket provided to you by?

15 A. St. Mary's.

16 Q. Okay. And when you are at St. Mary's Medical
17 Center do you wear that jacket?

18 A. Yes.

19 Q. Do you also wear any type of name tag,
20 identifying yourself when you're at St. Mary's in the
21 hospital?

22 A. Yes.

23 Q. And, sir, can you tell us what's on that name
24 tag please?

25 A. I believe it has my name, Berto Lopez, my

1 title, M.D., and St. Mary's Medical Center.

2 It may say obstetrics and gynecology or it
3 may say OBGYN, I don't remember which. And it has an
4 old photograph of me when I was younger and had more
5 hair, which I continue to use.

6 Q. Okay. Right. Do you place that name tag on any
7 particular part of your jacket?

8 A. Yeah, usually I put it here on the pocket
9 because it's got a little clip on, and then its got a
10 windup device where you can pull it out to swipe for
11 the controlled entry areas, like labor and delivery,
12 the parking lot.

13 Q. So, when you attend to patients at St. Mary's
14 Medical Center they're going to see on your body two
15 separate areas that say St. Mary's Medical Center: Your
16 name tag and your jacket?

17 A. Correct.

18 Q. Okay. Do you have a practice outside of
19 St. Mary's Medical Center?

20 A. Yes, I'm not an employee of St. Mary's.

21 Q. Were you -- back in January of 2011, did you
22 have any sort of private medical practice?

23 A. Yes.

24 Q. Tell me a little bit about that.

25 A. I work for Berto Lopez, M.D., P.A.

1 Q. Okay. When you see a patient normally at
2 St. Mary's Medical Center, do you tell them that you're
3 not an employee of St. Mary's Medical Center?

4 A. No.

5 Q. Do you ever tell patients that St. Mary's
6 Medical Center may not be responsible if you commit any
7 acts of negligence?

8 MR. MITTELMARK: Object to the form.

9 THE WITNESS: No.

10 BY MR. SILVA:

11 Q. Do you ever have any patients that you take care
12 of at St. Mary's Medical Center sign any paperwork that
13 would state that St. Mary's would not be responsible if
14 you commit any acts of negligence?

15 A. I don't know the answer to that because I
16 know the patients sign-off on a bunch of legal papers,
17 that anywhere contained in those legal papers may be a
18 statement indicating whether or not the hospital is
19 the hospital, and physicians are not the hospital
20 employees.

21 Q. Have you seen those documents before?

22 A. I've seen them in other hospitals, I just --
23 you know I don't particularly read them, because I'm
24 not an inpatient.

25 Q. Okay.

1 A. But in some facilities, and again, I've seen
2 some at St. Mary's that say various things, but I
3 cannot say or I can't speak to the issue as to what is
4 contained in the paperwork that the patients sign-off
5 on.

6 Q. Right. So, you don't know one way or the other
7 if any of those documents that the patient signs at
8 St. Mary's specifically states that St. Mary's Medical
9 Center is not responsible if you commit any acts of
10 negligence?

11 A. That's correct.

12 Q. Which hospitals, back in January of 2011, did
13 you have privileges at?

14 A. St. Mary's Medical Center, Good Samaritan
15 Medical Center, West Palm Beach Hospital -- which at
16 that time may have been called Columbia Hospital --
17 and Wellington Regional Medical Center.

18 Q. Let's start with St. Mary's. Is your
19 understanding that St. Mary's is owned by Tenet?

20 A. Yes.

21 Q. And is that the same for Good Samaritan?

22 A. Yes.

23 Q. Do you know who the corporate parent company is
24 of West Palm Beach Hospital?

25 A. I believe it's HCA.

1 Q. And what about Wellington?

2 A. It's UHS, I think it's Universal Health
3 Services or Systems.

4 Q. Okay. Back in January of 2011 where was the
5 location of your office?

6 A. I had two offices. One was at 1501
7 Presidential Way, Suite 21, West Palm Beach, Florida,
8 33401.

9 And my second location was at 10887 North
10 Military Trail, Suite 2, Palm Beach Gardens, Florida,
11 33410.

12 Q. Back in January 2011 did you have any partners
13 or associates in the practice?

14 A. I had, not as an employee, but Dr. Tum,
15 Vythiya Tum, M.D., is a physician with whom I
16 cross-covered with and shared office space in the West
17 Palm Beach office location.

18 Q. Dr. Tum, T-U-M, he was not affiliated with your
19 practice?

20 A. He's not -- he has a separate P.A. He is
21 affiliated in the practice in the sense that we
22 cross-cover one another. He assists me in surgeries
23 and Caesarian section deliveries.

24 Q. But he has his own P.A., and you have your own
25 P.A.?

1 A. Correct.

2 Q. And you do your own billing and he does his own
3 billing?

4 A. Correct.

5 Q. So you might assist each other with taking call
6 or assisting in certain procedures or surgeries?

7 A. Correct.

8 Q. Okay. How long have you been practicing OBGYN?

9 A. I've been in private practice since July 13,
10 '20 -- I'm sorry, 1987.

11 Q. 1987. And throughout your career up until today
12 have you ever performed a stat C-section?

13 A. Yes.

14 Q. How many would you say?

15 A. I don't know the exact number, I would
16 imagine over a hundred. I mean, I don't know the
17 exact number.

18 Q. I'm not going to hold you to it.

19 In any of those stat C-sections that you've
20 performed since you have been in practice, have you ever
21 performed a stat C-section by yourself?

22 A. Yes.

23 Q. And you're certainly comfortable and capable of
24 performing a stat C-section, if you need to, by yourself?

25 A. Yes.

1 Q. Have you ever had your privileges suspended,
2 denied, or limited in any way?

3 A. No.

4 Q. Have you ever served on any hospital's board of
5 trustees?

6 A. No.

7 Q. Have you ever been on any departments in the
8 medical staff?

9 A. Yes, I'm presently Vice-Chief of Staff at
10 West Palm Beach Hospital.

11 And I've been a member of the Medical
12 Executive Committee for over ten years at West Palm
13 Beach Hospital.

14 Q. What about at St. Mary's?

15 A. I'm presently on the Physician Leadership
16 Group.

17 Q. What's that?

18 A. That's a committee of physicians that thought
19 leaders that I guess we did -- it is an information
20 transfer between thought leaders and the facility's
21 administrators, so that both the thought leaders and
22 the facility leaders have an opportunity to exchange
23 ideas and make sure we meet each other's needs.

24 Q. Have you ever been on any committees at
25 St. Mary's Medical Center that were responsible for

1 creating policies or procedures?

2 A. I was a member of a quality assurance
3 committee, and we would review some policy and
4 procedures from time to time.

5 Q. Have you ever reviewed a policy and procedure at
6 St. Mary's Medical Center for titled emergencies within
7 perinatal units?

8 A. Yes.

9 Q. Including C-section emergencies?

10 A. Yes.

11 Q. Did you ever have any input in creating that
12 policy or procedure up until today?

13 A. No.

14 Q. Are you familiar with that policy and procedure
15 at St. Mary's?

16 A. Yes.

17 Q. And do you agree with everything on that policy
18 and procedure?

19 MR. MITTELMARK: Object to the form.

20 THE WITNESS: Obviously I haven't really
21 reviewed it within the context of that question,
22 so I don't know.

23 BY MR. SILVA:

24 Q. I'm going to hand you a copy of it in a second.

25 A. Okay.

1 Q. But I want to start out by asking you as far as
2 you know you're familiar with it, and have you ever had
3 any issues with that policy or procedure for emergency
4 C-sections?

5 MR. MITTELMARK: Object to the form.

6 THE WITNESS: If you will give me one moment
7 to quickly peruse it.

8 MR. SILVA: Sure. I'll mark my own copy as
9 plaintiff's Exhibit Number 1.

10 MS. WIDLANSKY: I want to make sure you have
11 the same thing.

12 THE WITNESS: 1.5.

13 MR. SILVA: You can show him my exhibit.

14 THE WITNESS: Yes, I have no issue with that.

15 (Plaintiff's Exhibit No. 1 was marked for
16 identification)

17 BY MR. SILVA:

18 Q. Let's start out with the title of this document
19 is: Emergencies Within Perinatal Units.

20 And below that it has: CS Emergencies. Does
21 that mean C-section emergencies?

22 A. Yes.

23 Q. And below that it has: Obstetrical Unit
24 Emergency Response. Are you aware of any other policies
25 and procedures at St. Mary's Medical Center that deal

1 with emergency C-sections or stat C-sections?

2 A. No.

3 Q. Does this document make any distinction between
4 emergency C-sections and stat C-sections?

5 A. Well, I guess it's a semantic opinion. It
6 says: To perform an emergency C-section without
7 delay. I don't see where it says -- okay, under
8 guidelines it has a stat C-section. And then it has
9 another category for obstetrical emergencies. So it
10 might be a semantic argument as to what is a stat and
11 what is an emergency.

12 Q. Sure. With regard to your practice as an OBGYN,
13 do you consider an emergency C-section and stat C-section
14 the same thing?

15 A. No.

16 Q. Tell me how you define a stat C-section in your
17 words.

18 A. A stat C-section is a C-section for an
19 obstetrical or maternal indication such as a prolapsed
20 umbilical cord, uterine rupture, placental abruption,
21 massive hemorrhage in obstetrical patients, that would
22 be considered stat.

23 Q. Anything else that you can think of for a stat
24 C-section?

25 A. Those are the ones that kind of come to mind

1 as blatantly stat.

2 Q. What about prolonged fetal bradycardia?

3 A. Well, it depends, because usually if you have
4 a prolonged fetal bradycardia there's a thing called
5 intrauterine resuscitative measures, which is a
6 nursing protocol that's agreed upon by the
7 obstetricians as a standing protocol to allow the baby
8 an opportunity to recover inside the uterus.

9 Q. If the baby does not recover inside the uterus
10 from fetal bradycardia, is that an indication for stat
11 C-sections?

12 A. It depends on what that failure of recovery
13 looks like. If the failure of recovery is a fetal
14 heart rate below, say, 60 beats per minute for greater
15 than 10 minutes, yes.

16 If there is a recovery, even though it may
17 take 10 minutes to recover, then no.

18 Q. Have you ever called a stat C-section for
19 persistent fetal bradycardia in your career?

20 A. Yes.

21 Q. Now, can you tell us, or the jury, what the
22 status of a baby's oxygenation rate is if they have had
23 persistent fetal bradycardia for a period of 10 minutes?

24 MS. WIDLANSKY: Form.

25 MR. MITTELMARK: Join.

1 MR. BLOOM: Join.

2 THE WITNESS: I'm sorry, could you repeat the
3 question?

4 BY MR. SILVA:

5 Q. Yes. Could you tell the jury what the fetal
6 oxygen saturation rate is for a baby who's has fetal
7 bradycardia for 10 minutes?

8 MS. WIDLANSKY: Form.

9 BY MR. SILVA:

10 Q. Is there any way to do that?

11 MR. MITTELMARK: Join.

12 MR. BLOOM: Join.

13 THE WITNESS: It depends on your definition
14 of fetal oxygenation rate.

15 BY MR. SILVA:

16 Q. What do you think fetal oxygenation rate means?

17 A. I'm not here to speculate on what it means.
18 I don't know. It's not a word -- it's not an art of
19 the trade word, so if you could define it any better
20 for me I'll be happy to answer your question.

21 Q. Let me ask you this: What is the art of the
22 trade word that determines how much oxygen a baby is
23 getting to its brain; what would you call that?

24 A. Well, I would call that a hypothetical
25 situation that has no basis in science, because we

1 don't have the capacity to measure the oxygenation
2 rate to a fetal brain in utero.

3 Q. So the answer to my question is there is no
4 capacity in medicine to do that, correct?

5 A. Accurately. You can make some deductions and
6 we have made some speculations as to what's going on
7 in terms of the oxygenation based on indirect
8 evidence, but we don't have a direct measure of fetal
9 oxygenation in an intrauterine pregnancy.

10 Q. Okay. And for the same question there is no way
11 to determine the fetal oxygenation for a baby whose had
12 fetal bradycardia for a period of five minutes, is there?

13 MS. WIDLANSKY: Form.

14 MR. BLOOM: Join.

15 THE WITNESS: Yes.

16 BY MR. SILVA:

17 Q. That's correct?

18 A. That's correct.

19 Q. Or two minutes, for that matter, correct?

20 A. Correct.

21 Q. Or any amount of time, correct?

22 A. Correct.

23 Q. Now, is there anything else that you can think
24 of that you said already that is an indication for a stat
25 C-section?

1 A. No.

2 Q. If a baby continues in a fetal heart rate of
3 fifties to sixties for an extended period of time, let's
4 say 20 minutes, can you tell us what the result of that
5 is?

6 MS. WIDLANSKY: Form.

7 MR. MITTELMARK: Join.

8 MR. BLOOM: Join.

9 THE WITNESS: It depends on the clinical
10 situation and it depends on the size of the baby.
11 It depends on many factors. It's generally not a
12 good thing, but, you know, there will be concerns
13 about whether or not the lack of sufficient
14 oxygenation which may have resulted in the fetal
15 bradycardia, the prolonged fetal bradycardia will
16 result in multiple organ injury of a permanent
17 nature.

18 BY MR. SILVA:

19 Q. Does that include the brain?

20 A. Yes.

21 Q. Have you seen in your career unborn babies, for
22 whatever reason, develop persistent fetal bradycardia
23 that leads to intrauterine death before the baby is
24 delivered?

25 A. Yes.

1 Q. So that is always a risk if an unborn baby
2 develops fetal bradycardia they can go on to have no
3 heartbeat and die?

4 MR. BLOOM: Form.

5 BY MR. SILVA:

6 Q. Isn't that true?

7 A. Yes, in one extreme and hypothetical, yes.

8 Q. Is that one of the indications for trying to get
9 a baby out as soon as possible if they have persistent
10 fetal bradycardia?

11 MR. BLOOM: Form.

12 THE WITNESS: Yes.

13 BY MR. SILVA:

14 Q. The purpose of this protocol that is created by
15 St. Mary's states: The purpose is to perform an
16 emergency C-section without delay. Do you see that?

17 A. Yes.

18 Q. What's the reason for trying to perform an
19 emergency C-section without delay as opposed to, you
20 know, the nurses going on a coffee break for some period
21 of time?

22 MS. WIDLANSKY: Form.

23 MR. MITTELMARK: Join.

24 MR. BLOOM: Join.

25 THE WITNESS: There may be some clinical

1 situations where there is a need for the
2 obstetrician to perform an emergency Cesarean --
3 an emergency Cesarean section without a delay.

4 BY MR. SILVA:

5 Q. Okay. And would one of those conditions be
6 persistent fetal bradycardia?

7 MS. WIDLANSKY: Form.

8 MR. BLOOM: Form.

9 THE WITNESS: Again, I said it depends on the
10 circumstances surrounding the etiology of the
11 fetal bradycardia.

12 What I mean by that is during the course of a
13 pregnancy when a mother is being monitored
14 continuously there are many times that a baby can
15 roll over onto the umbilical cord and you can
16 have a transient fetal bradycardia that would
17 resolve in intrauterine resuscitative measures,
18 meaning increasing oxygenation, change of
19 position of the mother, increasing IV fluids, and
20 of course alerting the physician of this change
21 in status.

22 So, there are cases where you can have a
23 bradycardia that resolves with intrauterine
24 resuscitative measures and do not require an
25 emergent Cesarean section without delay.

1 MR. SILVA: Move to strike response to my
2 question.

3 BY MR. SILVA:

4 Q. My question, Doctor, if you listen carefully, I
5 asked you for persistent fetal bradycardia is an
6 emergency C-section without delay an appropriate measure
7 of taking care of the patient?

8 MS. WIDLANSKY: Object to form.

9 MR. BLOOM: Form.

10 BY MR. SILVA:

11 Q. Not fetal bradycardia.

12 A. Persistent fetal -- how do you define
13 persistent?

14 Q. Well, what is your definition of persistent
15 fetal bradycardia?

16 A. I don't use the phrase "persistent."

17 Q. Well, what do you use to phrase -- since we are
18 talking about semantics and definitions here, then we'll
19 go through the dictionary. How do you define a patient
20 who's has an extended period of fetal bradycardia, as far
21 as the unborn fetus goes?

22 MS. WIDLANSKY: Object to form.

23 THE WITNESS: I generally use a descriptor
24 for the number of minutes.

25 BY MR. SILVA:

1 Q. Well, let's start with the least amount of fetal
2 bradycardia all the way to the most severe form of it,
3 give us all your definitions.

4 A. Well, five minutes --

5 MS. WIDLANSKY: Form.

6 THE WITNESS: Five minutes is my least amount
7 of time. And my greatest amount of time is
8 infinity.

9 BY MR. SILVA:

10 Q. Death, basically?

11 A. Well, if death is what the sequelae of the
12 prolonged bradycardia, yes.

13 Q. So, an unborn fetus that has had fetal
14 bradycardia for a period of five minutes -- well, how do
15 you classify that?

16 A. Five minute fetal bradycardia.

17 Q. How do you classify an unborn fetus that's had
18 fetal bradycardia for ten minutes?

19 A. Fetal bradycardia of ten minute duration.

20 Q. And what do you consider bradycardia for the
21 fetus?

22 A. Fetal heart rate below 110 beats a minute not
23 associated with a periodic change.

24 Q. What do you consider fetal tachycardia?

25 A. Fetal heart rate greater than 160 beats a

1 minute, that is not an accumulation of accelerations
2 that persists.

3 Q. And fetal acceleration, can that be a sign of
4 fetal distress?

5 A. If it's a compensatory acceleration after
6 deceleration, yes.

7 Q. And for the purposes of the jury, describe from
8 a physiological standpoint how -- if a fetus has fetal
9 bradycardia for some period of time, how the compensatory
10 mechanism causes fetal tachycardia?

11 MS. WIDLANSKY: Form. If you know?

12 MR. SILVA: I mean he's an OBGYN. Go ahead.

13 THE WITNESS: It pretty much is the same as a
14 near choking person. If there is a diminishing
15 of oxygenation to the fetal heart, the heart rate
16 will slow down over time with increasing acidosis
17 and the hypoxemia.

18 And then if there is a resolution of that
19 hypoxemia, the heart rate overcompensates as
20 oxygen becomes available, and actually
21 accelerates in an effort to establish what is
22 called homeostasis for the rest of the body.

23 In other words, the heart will run faster in
24 order to pump more blood, so the peripheral
25 tissues will receive as much oxygenation as the

1 blood that's available has.

2 BY MR. SILVA:

3 Q. Okay. And is that the fetus' physiological
4 response to hypoxemia?

5 A. It's one of them, yes.

6 Q. Did you review the fetal heart monitor strips
7 for the unborn baby of Heather McCants before her
8 delivery?

9 A. Yes.

10 Q. And did you conclude that the baby had a fetal
11 bradycardia for some period of time?

12 A. Yes.

13 Q. Did you conclude that the baby had fetal
14 tachycardia for a period of time?

15 A. A brief period of time that was recorded,
16 yes. No, excuse me, not really tachycardia. Not
17 tachycardia in the definition of a fetal heart rate
18 above 160.

19 A compensatory tachycardia in that it went
20 above the baseline that was existing prior to the
21 bradycardic event at, pardon the expression, I'm going
22 to say 15 -- around panel 75127, which I guess I can
23 call 15:07.

24 Q. Okay. Is that 3:07 in the afternoon?

25 A. Yes, it is.

1 Q. So you would -- what happened at 3:07 as far as
2 the fetal heart monitor strips?

3 A. It dove from a baseline heart rate of about
4 150 to 155, all the way down to approximately 50 beats
5 per minute.

6 Q. And did you understand, did somebody give you
7 the history that this sudden loss of heart rate into a
8 bradycardic level occurred shortly after an injection of
9 Cathflo in Heather McCants?

10 MS. WIDLANSKY: Form.

11 MR. MITTELMARK: Object to the form.

12 MR. BLOOM: Join.

13 THE WITNESS: Yes, Nurse Duckworth explained
14 that to me.

15 BY MR. SILVA:

16 Q. Did Nurse Duckworth tell you that Heather
17 McCants had a respiratory arrest after the Cathflo?

18 MR. MITTELMARK: Object to the form.

19 MS. WIDLANSKY: Join.

20 THE WITNESS: Yes.

21 BY MR. SILVA:

22 Q. Now this -- this showed you had the fetal
23 bradycardia you said starting at about 3:07?

24 A. Approximately.

25 Q. How long did that continue for?

1 A. I think between almost, you know, nine
2 minutes, possibly ten.

3 Q. Okay. And then there is a physiological
4 response of fetal tachycardia; is that what you're
5 describing earlier when a baby becomes hypoxic they can
6 have a response like that?

7 A. They can have an overshoot, yes.

8 Q. Okay. And did you see an overshoot in the fetal
9 heart rate in this case?

10 A. Actually I received that as a report from
11 Nurse Duckworth.

12 When I actually reviewed the strips the heart
13 rate actually went back up to the 150's, which was
14 basically, you know, recompensated to baseline.

15 Q. Were you aware that the fetal heart rate was in
16 the 160's to 165 in the operating room?

17 A. Yes.

18 Q. You were?

19 So that fetal heart rate of 160 to 165, would
20 that correspond to that type of compensation we were
21 talking about earlier?

22 A. Well, it's more than that because at that
23 time the mother was in the operating room, the mother,
24 herself, Ms. McCants, had a tachycardia herself, a
25 maternal tachycardia. And her heart rate was in the

1 150's, 160's in the operating room and through a
2 portion of the surgery. And then ultimately settled
3 into the 140's, as I recall.

4 Q. Well, were you aware that Heather McCants had
5 tachycardia in the 120's when her baby's heart rate was
6 in the fifties?

7 A. Yes.

8 Q. Okay. And so were you aware that at around 3:30
9 to 3:32 in the afternoon the baby's heart rate was in the
10 160's to 165's on fetal heart monitor?

11 A. Yes.

12 Q. Would this response be due to a hypoxemia?

13 MS. WIDLANSKY: Form.

14 THE WITNESS: It could be due to many things,
15 as I mentioned. There were a number of maternal
16 issues. This was a mother who had prolonged
17 rupture of membranes. And there is a
18 differential diagnosis that goes into play when
19 the membranes have been ruptured for an extended
20 period of time, you know.

21 You have to consider, are we dealing with an
22 issue of infection like chorioamnionitis or
23 sepsis.

24 Are we dealing with an issue of, you know,
25 with a maternal tachycardia is this compensation

1 because, as you know, the baby gets oxygenated
2 during diastole. And when the mother's heart
3 rate is higher than a hundred really, the amount
4 of time in diastole is greatly diminished and her
5 heart rate was in the 150's, sometimes the 160's
6 and then downtrended into the 140's after the
7 baby was delivered.

8 The other concern was had this mother
9 sustained either a pulmonary embolism, which
10 would make both the mother potentially hypoxic or
11 have just equilibrium between the mother's
12 oxygenation and ventilation, that would also
13 affect the baby because if the mother's
14 oxygenation was not good it might affect the
15 baby's oxygenation.

16 This is a mother who is morbidly obese. And
17 if the mother was in a position like, for
18 example, flat on her back, it's possible that
19 some component of it could be due to vagal
20 compression meaning, or you know inferior cava
21 compression.

22 So, there are multiple factors that would go
23 into a differential diagnosis pattern. So, but
24 at the end of the day, when the rubber hits the
25 road the mother's heart rate was excessively fast

1 after whatever incident had happened, where
2 before it was not as fast as it was.

3 And certainly the baby had some fetal heart
4 rate monitoring issues that were initially
5 bradycardia, but then turned into a tachycardia.

6 So, there were issues for both the mother and
7 the baby and how they interplayed could be a
8 complex thing. But the mother's heart rate
9 wasn't normal and the baby's heart rate wasn't
10 normal either.

11 BY MR. SILVA:

12 Q. So again, can fetal hypoxemia from fetal
13 bradycardia result in a rebound fetal tachycardia?

14 A. For a short period of time, yes. But if it
15 were a persistent fetal oxygen lack, the heart rate
16 would stay low, wouldn't rebound, because there's not
17 enough oxygen to feel the heart beating.

18 Q. Yes. And in this case, I think you told us
19 earlier, that you have no idea how to determine what the
20 fetal oxygenation rate is, correct, in utero?

21 A. To my knowledge there is no way to accurately
22 measure the fetal oxygenation rate by direct evidence.

23 Q. Now, you talked about some different issues here
24 and you threw out some words, so let's go through them
25 one by one.

1 Chorioamnionitis: Did you ever see any results
2 on the placenta pathology that this mother had
3 chorioamnionitis?

4 A. The report itself does not indicate evidence
5 of infection. However, it was processed as a routine
6 specimen. I did not see evidence that the pathologist
7 specifically looked for evidence of chorioamnionitis.

8 Q. Did you tell the pathologist to look for
9 specific evidence of chorioamnionitis as the delivering
10 OB?

11 A. Not as of yet, but I can. The placenta is
12 preserved so a review of the placenta can certainly be
13 established.

14 Q. Well, if you were concerned about
15 chorioamnionitis why would you not have told the
16 pathologist to look for it specifically?

17 A. Because I was only concerned about
18 chorioamnionitis before the delivery. After the
19 delivery, the delivery has been affected. Whether or
20 not chorioamnionitis is one or could potentially be
21 one of the causes of the clinical scenario, the result
22 would still be delivery.

23 So, she was going to be delivered whether she
24 had chorioamnionitis or there was even a suspicion of
25 chorioamnionitis.

1 Q. Well, did you know at some point in time that
2 this baby ended up with periventricular
3 leukoencephalopathy and cerebral palsy?

4 A. Did I know that? Do I know that now? Yes.
5 Did I know that at the time? No.

6 Q. Did it ever occur to you that you might want to
7 know what the cause was of periventricular
8 leukoencephalopathy and cerebral palsy?

9 Did you ever consider doing a workup for the
10 causation of that issue?

11 MS. WIDLANSKY: Form.

12 MR. BLOOM: Join.

13 THE WITNESS: Well, as her obstetrician and
14 the baby's obstetrician, prematurity is the
15 leading cause of periventricular leukomalacia and
16 cerebral palsy. So this baby was initially
17 admitted and transferred from Indian River
18 Hospital was already at significant risk for
19 cerebral palsy and periventricular leukomalacia
20 just on the basis of prolonged ruptured
21 membranes.

22 This baby came in with that risk factor and
23 that risk factor never went away. And she was
24 given prophylactic antibiotics as a standard of
25 care. And she received surveillance as would be

1 standard of care.

2 And when there was an evidence of an
3 elevation in the fetal heart rate and an
4 elevation in the maternal heart rate, a delivery
5 ensued in a timely fashion.

6 BY MR. SILVA:

7 Q. Can babies who are premature have cerebral palsy
8 as a result of hypoxemia?

9 A. Yes.

10 Q. Okay. Now, do you know as an obstetrician if
11 premature babies are even more sensitive to episodes of
12 hypoxemia because of the prematurity in utero?

13 A. Yes.

14 Q. They are, correct?

15 A. Yes.

16 Q. Okay. So, any period of hypoxemia may cause
17 more injury to the organs, including the brain, in a
18 premature unborn child than, say, in a 39 or 40-week
19 unborn child; you'd agree with that?

20 MR. MITTELMARK: Object to the form.

21 MS. WIDLANSKY: Join.

22 MR. BLOOM: Join.

23 THE WITNESS: Yes.

24 BY MR. SILVA:

25 Q. Now, you also mentioned a couple other things

1 here. Talking about the mother being morbidly obese as
2 having -- if she's laying on her back that might affect
3 the blood flow to the uterus and the baby, right?

4 A. Right.

5 Q. Would you expect the OB nurses, if they're faced
6 with a mother who has a fetal heart strip with a baby's
7 heart rate in the fifties to make an adjustment to the
8 mother's position to determine if that was causing any
9 sort of compromise to the fetus?

10 A. Yes, I would.

11 Q. That's -- the standard of care requires that?

12 A. Yes.

13 Q. Then you talked about pulmonary embolism could
14 be -- could potentially be a cause of the mother not
15 getting enough oxygen into her bloodstream, and then in
16 turn not getting enough oxygen to the baby.

17 Did you diagnose Heather McCants with pulmonary
18 embolism?

19 A. No, I did not.

20 Q. Do you know if anyone did?

21 A. She did have an evaluation. As I mentioned
22 before when I was notified of her status, and my
23 differential diagnosis was the possibility of
24 pulmonary embolism. She was not -- she had a positive
25 Dimer Test, and I believe a negative workup for a

1 pulmonary embolism.

2 Q. Okay. Did you have in your differential
3 diagnosis, before you deliver the baby, that the mother
4 could have a pulmonary embolism?

5 A. Yes.

6 Q. Did you having a pulmonary embolism in your
7 differential diagnosis in any way delay the delivery of
8 her baby?

9 A. No, it did not.

10 MS. WIDLANSKY: You need to take that?

11 THE WITNESS: No.

12 BY MR. SILVA:

13 Q. Did you do any type of workup for pulmonary
14 embolism prior to the delivery?

15 A. No. What I did was I -- prior to the
16 delivery I notified the internal medicine service so
17 that a workup could be instituted as quickly after the
18 delivery was affected.

19 Q. Okay. Other than notifying the internal
20 medicine service did you do anything else with regard to
21 working up Heather McCants for pulmonary embolism?

22 A. In light of the fact that some of the
23 diagnostic tests can't be performed when a patient is
24 pregnant, for example, you are not going to do a
25 spiral CT scan because CT scans involve radiation and

1 radiation can be harmful to a baby, I made
2 arrangements for the evaluation to occur after the
3 baby had been delivered.

4 So I notified the internal medicine service,
5 I think, Dr. J-U-M-P-O-A-O-A, or something like that,
6 to be aware of what I had in terms of the clinical
7 presentation of Ms. McCants, and for her to be
8 available immediately for the evaluation, the
9 diagnosis, and treatment of her respiratory
10 decompensation.

11 Q. So going back to my original question, besides
12 calling the internal medicine department did you do
13 anything else to workup Heather McCants before her baby
14 was delivered, for pulmonary embolism?

15 MS. WIDLANSKY: Form, asked and answered.

16 MR. SILVA: Wasn't answered.

17 THE WITNESS: As my scope and practice is
18 obstetrics the management of pulmonary embolism,
19 and diagnosis and treatment of pulmonary embolism
20 really falls more into the realm of internal
21 medicine.

22 So I did not personally order testing for a
23 pulmonary embolism. I did not order testing that
24 would in any way delay with the proceeding to an
25 emergent Cesarean section.

1 BY MR. SILVA:

2 Q. And did you consider this an emergency Caesarian
3 section?

4 A. Well, you are misquoting what I said. Listen
5 very carefully. Emergent. You make the same mistake
6 that happens from time to time. An emergent --

7 Q. I'm not making a mistake.

8 A. Excuse me, sir, let me finish my answer.

9 Q. Well, don't put words in my mouth, okay?

10 A. Well, don't put them in mine.

11 Q. We'll get to it in a second.

12 A. Emergent Cesarean section, sir.

13 Q. Go ahead. Emergent?

14 A. Yes, emergent. You know the word emergent.

15 Q. Is there a difference between emergent and
16 emergency?

17 A. Yes.

18 Q. Tell me the difference.

19 A. An emergent Cesarean section is a Cesarean
20 section performed as quickly as an operating room and
21 anesthesia is available to effect delivery.

22 Q. Emergency?

23 A. Emergent.

24 Q. Emergent?

25 A. Yes.

1 Q. Is as quick as possible?

2 A. As quick as anesthesia and operating room can
3 be summoned for the performance of a Cesarean section,
4 that's called an emergent.

5 Q. Emergent. And what's the difference between
6 that and an emergency Cesarean section?

7 A. I don't know what an emergency Cesarean
8 section means.

9 I know that there is stat C-sections, and I
10 know there are emergent C-sections, and I know there
11 are routine C-sections.

12 I mean, I assume we can come up with a whole
13 spectrum of hurry up C-section, or let's get it done
14 as soon as we can C-section, or let's do one after
15 lunch C-section, but the categories that I'm familiar
16 with are: Stat, which this was not; routine, which
17 this was not; and emergent, which is what I asked for.

18 Q. Okay. That's amazing, because I'm going to have
19 you look at plaintiff's Exhibit Number 2, which is your
20 discharge summary dictation, sir.

21 And I want you to read into the record, starting
22 with the fourth sentence in your discharge summary, where
23 it says: She had -- she had had. Okay?

24 A. Okay. You mean she underwent?

25 Q. No.

1 MS. WIDLANSKY: The line above that.

2 THE WITNESS: I'm sorry. Which line?

3 BY MR. SILVA:

4 Q. Five lines down. The first sentence, five lines
5 down.

6 A. She had an episode of hypoxemia, is that the
7 one?

8 Q. Yes, start there.

9 A. She had an episode of hypoxemia after a
10 central line catheter was flushed.

11 Q. Read the next sentence.

12 A. She underwent an emergency repeat C-section.

13 Q. You told me you never heard the word emergency
14 as far as C-sections go.

15 A. The transcriptionist made the same mistake
16 you did. She wrote emergency, but I said emergent.

17 Q. I see. So --

18 A. And not only that, but I didn't sign it.

19 Q. Okay. Well, go ahead and read the rest of that
20 sentence into the record so it's clear.

21 A. She underwent an emergency repeat Cesarean
22 section because of prolonged fetal deceleration and
23 persistent fetal tachycardia under spinal anesthesia
24 on 1/26/2011, period.

25 (Plaintiff's Exhibit No. 2 was marked for

1 identification)

2 BY MR. SILVA:

3 Q. Did you sign this document?

4 A. No, because I didn't correct it.

5 Q. Okay. Do you know what the policy and procedure
6 is at St. Mary's Medical Center for doctors signing-off
7 on medical records?

8 A. Yeah, I think you're supposed to do it within
9 30 days.

10 Q. Did you do that in this case?

11 A. No, but that caused no harm to Ms. McCants.

12 Q. No, it didn't, but you didn't follow the policy
13 and procedure, did you?

14 A. No.

15 Q. Why didn't you make the correction to this
16 dictation if you thought it needed to be dictated?

17 A. I think I had to dictate it because I'm
18 required to dictate it.

19 Q. Why didn't you go back and correct this
20 dictation to say emergent instead of emergency?

21 A. I will. I can. There is no limitation in
22 terms of when I can make a correction. Since it's
23 unsigned it is clearly not completed.

24 Q. Is that your testimony that there is no limit to
25 correcting your medical records, no limit in time?

1 A. I didn't say that.

2 Q. Is there a limit to correcting your medical
3 records at St. Mary's Medical Center?

4 A. No, not that I'm aware of. I think they're
5 supposed to be done within 30 days.

6 Q. Okay. And up until today you haven't gone back
7 and made any corrections to this discharge summary,
8 correct?

9 A. Correct.

10 Q. Now, I want you to look at plaintiff's Exhibit
11 Number 1, and can you tell me where it refers to emergent
12 C-section as opposed to emergency C-section?

13 A. Well, I don't see emergency C-section
14 described.

15 Q. Well, I think we've been through this before.
16 Doesn't it say: The purpose to perform an emergency
17 Caesarian section without delay; do you remember that?

18 A. Yes.

19 Q. So, did you ever tell St. Mary's that you
20 disagreed with their policy and procedure that instead of
21 emergency it should say "emergent"?

22 A. No, I think what they're talking about is a
23 stat C-section, because they go on to describe a stat
24 C-section.

25 Q. Do you know if a policy and procedure at

1 St. Mary's exists for an emergency C-section?

2 A. No.

3 Q. Do you know if a policy or procedure at
4 St. Mary's exists for, your term, emergent C-section?

5 A. Well, it's not only my term, that is the term
6 of the craft.

7 No, no policy. I don't think a facility can
8 have a policy and procedure for every possible
9 scenario. And since guidelines and ideas change and
10 sometimes are in flux, I don't necessarily think that
11 you have to protest a policy and procedure if the
12 policy and procedure is generally, you know, within
13 some sort of acceptable standard.

14 Q. Does an emergent C-section require the delivery
15 of the child without delay?

16 A. An emergent Caesarian section is defined as a
17 Cesarean section that is performed as quickly as the
18 patient and the anesthesia department can get the
19 patient ready for delivery.

20 Q. Okay.

21 A. If that means without -- I'm not sure -- the
22 problem I have is what is a delay. Now, sometimes
23 there are delays because the elevators aren't
24 available; the patient is obese, requires to be taped
25 up.

1 There may be a delay because if a patient is
2 obese you have to wash them with Betadine and you may
3 have to use more than one prep stick. And it takes
4 four to five minutes to dry. Is that a delay or is
5 that standard?

6 So, the trouble I have is if you are talking
7 about a delivery without delay I think you are
8 describing a stat. Emergent means you do it as
9 quickly as you poss -- you do it as quickly as you can
10 prudently get the team together and the patient setup
11 in a safe manner consistent with the standard of care.

12 Q. Okay, I just want to be clear for the jury.

13 According to your definition, an emergent
14 C-section is doing a C-section as quickly as possible, as
15 quickly as you can get the OB and the anesthesia and the
16 nurses to perform the procedure?

17 A. That's right. That's the definition. It is
18 not only my definition, it is a generally accepted
19 definition.

20 Q. Okay. And is there any -- in that definition is
21 there any ability to delay the procedure for any reason?

22 MR. MITTELMARK: Object to form.

23 THE WITNESS: I don't know what you mean by
24 delay.

25 BY MR. SILVA:

1 Q. I'm going to specify for you.

2 Is it okay under your definition of an emergent
3 C-section for the nurses to go on a coffee break?

4 MS. WIDLANSKY: Form.

5 MR. BLOOM: Form.

6 THE WITNESS: It is an incomplete
7 hypothetical. I don't know what you mean.

8 BY MR. SILVA:

9 Q. Okay. If you call an emergent C-section is it
10 okay for the nurses to go on a coffee break for five
11 minutes?

12 MS. WIDLANSKY: Form.

13 THE WITNESS: No.

14 BY MR. SILVA:

15 Q. That would be a violation of the standard of
16 care, wouldn't it?

17 A. Well, it depends. It depends -- a violation
18 of the standard of care would be if the nurses went on
19 a coffee break after an emergent C-section was called,
20 and that delay caused harm to someone.

21 So there are other standards that apply to be
22 a breach of a standard of care.

23 Q. Well, I'm not talking about causation, sir, I'm
24 talking about the standard of care.

25 Would it be a breach of the standard of care for

1 an emergent C-section to be called and for the nurses to
2 go on a coffee break for five minutes?

3 MS. WIDLANSKY: Form.

4 THE WITNESS: Yes, in general. But that's
5 not what happened here.

6 MR. MITTELMARK: And I'll stipulate to that
7 one.

8 MR. SILVA: Of course you will.

9 BY MR. SILVA:

10 Q. In this case your testimony is that there is no
11 delay in taking this baby out; is that your testimony?

12 A. My testimony is this patient received an
13 emergent Cesarean section consistent with the care
14 that was indicated.

15 Q. And, let's get back to some of the preliminaries
16 here.

17 Have you ever taken any time off from the
18 practice of medicine?

19 A. No. Well, I mean, vacation -- you mean have
20 I ever gone on vacation? Yeah.

21 Q. Have you ever taken any extended period of time
22 for any reason?

23 A. From the practice of medicine?

24 Q. Yes.

25 A. No.

1 Q. Are you on any medications today?

2 A. Yes.

3 Q. Anything that would affect your ability to
4 testify?

5 A. No.

6 Q. Okay. Have you ever been arrested for anything?

7 A. No.

8 Q. Ever been convicted of a crime?

9 A. No.

10 Q. Ever been accused of any issues regarding sexual
11 issues with a patient?

12 A. No.

13 Q. Okay. Ever been sued for medical malpractice?

14 A. Yes.

15 Q. How many times?

16 A. The national average number of times I think
17 I can say, theoretically, seven times.

18 Q. Seven times?

19 A. Yes.

20 Q. Okay. So, out of all of those involved
21 deliveries of babies?

22 A. Well, I mean a patient that was pregnant had
23 appendicitis and a surgeon delayed doing the
24 appendectomy. I was sued for that. I don't think
25 that was involving the delivery of the baby, but it

1 was the care of an obstetrical patient.

2 I had a uterine perforation, I believe, that
3 was not pregnancy related because it was after the
4 pregnancy. But the majority of them would be, yes.

5 Q. The other five, you think? The seven times,
6 does that include this one?

7 A. Yes.

8 Q. Have you ever been sued for delay in performing
9 a C-section?

10 A. Yes.

11 Q. How many times?

12 A. At least once.

13 Q. Well, can you be more specific?

14 A. Once I can think of.

15 Q. More than once or just once?

16 A. Once.

17 Q. Did that result in the baby being brain damaged?

18 A. She was delivered the following day by
19 another obstetrician who continued Pitocin for another
20 amount of time, yes.

21 Q. Do you remember the name of that case?

22 A. Yes, Hicks versus Lopez, and et. al.

23 Q. Was that in Palm Beach County?

24 A. It was.

25 Q. And, generally speaking, what year was that?

1 A. I think it initiated in 1988 or 19 -- yeah,
2 1988.

3 Q. Did you give a deposition in that case?

4 A. Yes.

5 Q. How many depositions have you given in your
6 career?

7 MS. WIDLANSKY: As a defendant in a case?

8 BY MR. SILVA:

9 Q. As a defendant.

10 A. Including today, probably five, maybe six.

11 Q. Do you know if the policies and procedures for
12 C-sections at St. Mary's have changed over the last ten
13 years?

14 A. I don't know with certainty.

15 Q. What is your definition of fetal distress?

16 A. I don't use the word fetal distress, I use
17 the word nonreassuring fetal heart rate panel.

18 Q. Has the definition of fetal distress been used
19 in the past in the OBGYN literature?

20 A. Yes.

21 Q. When?

22 A. I don't know.

23 Q. Do you go to medical meetings and continuing
24 medical education classes?

25 A. Yes.

1 Q. And you don't recall when fetal distress was
2 stopped using in the OBGYN literature?

3 A. Well, it depends on which literature and it
4 depends on which organization.

5 I'm sure I could do research and find out
6 when the use of birth asphyxia and fetal distress,
7 which are relatively nonspecific terms, was flipped
8 over to nonreassuring fetal heart rate pattern.

9 But, you know, in the world of obstetrical
10 literature we look to other places other than the
11 United States for research and guidance.

12 Q. So, do you know what the meaning of fetal
13 distress is?

14 A. Do I know what the meaning of fetal distress
15 is?

16 Q. Yes.

17 A. Well, it depends. If you could use it in a
18 sentence I would tell you how I would translate it --
19 you know there is doctor talk and then there is --
20 then there's regular English.

21 In doctor talk fetal distress is not a word
22 of the art for obstetricians, but it persists in legal
23 journals, it persists in the general vernacular. It
24 exists in the Twitter sphere.

25 Q. I see. Is it your testimony that the term fetal

1 distress has never appeared in medical literature?

2 MS. WIDLANSKY: Object to the form.

3 MR. MITTELMARK: Form.

4 THE WITNESS: I'm not saying that. I'm not
5 saying that at all. I'm saying as a phrase with
6 specificity and sensitivity within a scientific
7 journal or scientific discussion among
8 obstetricians it is not generally considered a
9 sophisticated, well-defined, specific and
10 sensitive definition.

11 You are a physician yourself. So you
12 understand there is technical talk within the art
13 of medicine, and then there is talk among the
14 general population.

15 BY MR. SILVA:

16 Q. Did you bring a CV with you today?

17 A. Of course.

18 Q. Can I see it?

19 A. Sure. (Handing)

20 Q. Have you ever published any articles on
21 obstetrics?

22 A. During my resident research period in the
23 Department of Obstetrics and Gynecology we had to do
24 research projects, and they were published with the
25 Department of Obstetrics and Gynecology, but in a peer

1 review journal, no.

2 Q. So, I'm looking at your CV. It's three pages
3 long. I don't see an area here for any peer reviewed
4 publications; is that correct?

5 A. Correct.

6 Q. So you can't give me a definition for fetal
7 distress?

8 MS. WIDLANSKY: Form.

9 THE WITNESS: I can give you many definitions
10 of fetal distress, but again, if you are talking
11 about doctor talk, physicians involved in writing
12 articles, and the word that has specificity and
13 sensitivity, the term that has been used for
14 several years now is nonreassuring fetal heart
15 rate pattern.

16 If we are talking about People Magazine, if
17 we're talking about the Palm Beach Post, fetal
18 distress is a baby in trouble. But it's not a
19 word that is used within the scientific
20 obstetrical community because it lacks
21 sensitivity and specificity.

22 BY MR. SILVA:

23 Q. And what is the definition of a nonreassuring
24 fetal pattern?

25 A. A pattern of electronic fetal monitoring

1 which may indicate that the baby is at risk for
2 acidosis or hypoxemia.

3 Q. Can that include fetal bradycardia?

4 A. Yes.

5 Q. Can that include fetal tachycardia?

6 A. Yes.

7 Q. Is that -- is there any other terminology in
8 medicine used now besides nonreassuring fetal pattern to
9 describe a baby in fetal distress?

10 A. Now, when you say "now" are we talking about
11 today, August the 26th, 2013 (sic)? Or are we talking
12 about January 26, 2011?

13 Q. Let's focus on January 2011.

14 A. Okay. Yes, you can use descriptive terms to
15 describe exactly what you're seeing or what you have
16 seen or what you think you have seen, or what has been
17 reported to be seen as a descriptive, without going to
18 other terminology.

19 Q. Okay. Is a nonreassuring fetal pattern an
20 indication for stat C-section?

21 A. It can be. It can also be an indication for
22 emergent Cesarean section, depending on what it is
23 that is nonreassuring. And whether or not the
24 nonreassurance is persistent and ongoing, as opposed
25 to was something that was seen but corrected, but

1 still indicated a need for delivery.

2 Q. Who do you think is in the best position to
3 determine all these factors when fetal heart pattern is
4 looked at, an OBGYN or an OB nurse?

5 MS. WIDLANSKY: Form.

6 THE WITNESS: It depends on the nurse and it
7 depends on the doctor. If you have a freshly
8 minted OBGYN doctor sometimes a 30-year veteran
9 nurse might be better to guide that young doctor
10 around, believe it or not.

11 BY MR. SILVA:

12 Q. What about an OBGYN who has been in practice
13 22 years compared to an OB RN; who do you think is in a
14 better position to determine --

15 MS. WIDLANSKY: Form.

16 THE WITNESS: Again, it depends on the nurse
17 and it depends on the doctor. I've seen some
18 doctors that can't read a fetal heart rate strip
19 and I've seen some nurses that can't read fetal
20 heart rate strip.

21 It depends on the doctor and depends on the
22 nurse and it depends on the interpretation
23 relative to a standard.

24 BY MR. SILVA:

25 Q. Right, right. Those doctors you have seen in

1 the past that couldn't read a fetal heart monitor strip,
2 you're talking about OB's, right?

3 A. Yeah. We have seen some that trained outside
4 the United States that did not have the benefit of
5 electronic fetal monitoring until they arrived here.
6 Although they had many years as practicing obstetrics
7 in some countries, they did not meet what I would
8 consider the standard that you would expect, and
9 certainly I would expect as a physician reviews the
10 work of other doctors.

11 Q. Right. What kind of nurses, OB nurses have you
12 observed in your career that couldn't read fetal heart
13 monitor strips?

14 A. Well, sometimes it depends on the situation.
15 There are some hospitals, I'm not saying St. Mary's,
16 there are some hospitals that I've practiced out of
17 where when they run short of nurses on labor and
18 delivery they pull telemetry nurses to come down and
19 watch the strips.

20 Q. Right.

21 A. So I don't know -- I don't know why they do
22 that. I haven't seen that at St. Mary's but I have
23 seen it in other facilities.

24 Q. Is it possible that it could occur at St. Mary's
25 also?

1 A. Never.

2 Q. How do you know that?

3 A. Well, let me say this: I've been there since
4 July of 1987, it has never happened at St. Mary's to
5 my knowledge.

6 Q. To your knowledge?

7 A. To my knowledge, to my patients.

8 Q. And you're not in the hospital 24 hours a day,
9 seven days a week everyday, correct?

10 A. Correct, but I practiced in a two-man call
11 group, a three-man call group. I've been to the
12 hospital more days than not.

13 And I certainly would have been -- had it
14 happened it would have created quite the buzz.

15 Q. Why?

16 A. Because this is a high quality hospital that
17 would never substitute a labor and delivery nurse or a
18 nurse that had electronic fetal monitoring
19 capabilities just to fill in a shortage of nurses.

20 Q. And because the standard of care requires it,
21 right? That you have doctors and nurses who know how to
22 read fetal heart monitor strips that are taking care of
23 pregnant women?

24 A. Oh yeah, St. Mary's they test those nurses
25 every year or every two years, yeah.

1 Q. And are you involved in that testing?

2 A. No, but I see them going to class. See them
3 coming out of class.

4 Q. Do you get tested in any way at St. Mary's as an
5 OB?

6 A. Well, we have to be recredencialled. And in
7 our recredencialling process we have to show evidence
8 that we are taking continuing medical education
9 courses. And they can review all the courses we have
10 taken and see where we have studied and recertified
11 it.

12 Q. And are you familiar with any of the Florida
13 Administrative Codes or any of the Florida Statutes for
14 the adequacy of medical records?

15 A. Yes.

16 MS. WIDLANSKY: Form.

17 THE WITNESS: Yes, I've read them from time
18 to time.

19 BY MR. SILVA:

20 Q. Are you aware the rules and regulations in the
21 state require physicians and health care practitioners to
22 document the medical records any time they have any
23 interaction with a patient?

24 A. Okay. If that's the standard then that's --
25 I mean I certainly have not memorized every standard,

1 but if that's the standard, that's the standard.

2 Q. Is that your practice?

3 A. If that's the standard then it's my practice.

4 Q. Okay.

5 A. Until proven otherwise.

6 Q. And do you know -- do you know the exact
7 standard?

8 A. Well, you know, are you talking about the
9 Administrative Code standard?

10 Q. Yeah.

11 A. I don't know it off the top of my head, but
12 if you have it in your hand and you want to show it to
13 me, I'll be happy to read it, review it and discuss it
14 with you, but I am familiar the adequacy of medical
15 records administrative code.

16 Q. Do you know if a late entry is made into the
17 records it should be noted so as a late entry, and timed
18 and dated?

19 A. Yes.

20 Q. And where did you gain that knowledge?

21 A. That's Recordkeeping 101.

22 Q. That's the standard of care for keeping medical
23 records?

24 A. Right. Whether or not it's in the
25 administrative code, yes.

1 Q. But you would consider that the standard of
2 care?

3 A. That is one of many standards, yes. In
4 general, for a late entry you would record it as a
5 late entry. You date and time it, or if you were
6 doing a correction of, for example, a dictated
7 discharge summary you could alter it and correct it.
8 And sign it. Date it, time it and sign it.

9 Q. And why is it done that way?

10 A. So that everyone can know when it was -- when
11 it was modified.

12 MR. SILVA: Okay. I'm going to mark the
13 standards for adequacy of medical records as
14 plaintiff's Exhibit Number 4. And I'll mark
15 Exhibit Number 3 as Berto Lopez' CV.

16 (Plaintiff's Exhibits No. 3 & 4 were marked for
17 identification)

18 BY MR. SILVA:

19 Q. Have you ever seen that document before, sir?

20 A. Yes.

21 Q. In what setting?

22 A. I've read it before off the website.

23 Q. You went on the Florida Administrative Code
24 website and read it?

25 A. Yes.

1 Q. Do you expect the nurses at St. Mary's Medical
2 Center to abide by that guideline also --

3 MR. MITTELMARK: Object to form.

4 MS. WIDLANSKY: Form.

5 BY MR. SILVA:

6 Q. -- when taking care of your patients?

7 A. Nurses have a different standard from the
8 board of nursing. This is from, if I'm not mistaken,
9 the Florida Administrative Code that deals with
10 physicians.

11 Q. Okay. You think that code only applies to
12 physicians and not nurses?

13 A. Well, when I've looked at this code -- and in
14 fact if we can take a break here, we can look at the
15 label of where the code comes from, and I think it's
16 from the Board Of Medicine.

17 Q. Okay.

18 A. As opposed to the Board of Nursing, which
19 regulates nurses.

20 Q. You understand the difference between a Florida
21 Administrative Code and a Florida Statute?

22 A. Yes.

23 Q. Okay. And your testimony is that this Florida
24 Administrative Code applies only to physicians and not
25 nurses?

1 MS. WIDLANSKY: Form, mischaracterization of
2 testimony.

3 BY MR. SILVA:

4 Q. Is that what you said?

5 A. What I'm saying is the Florida Administrative
6 Code, as I recall, from purviewing the website was in
7 reference to medical doctors.

8 There may be a similar element -- I'm not a
9 nurse. I'm not pretending or -- you have my CV, so
10 you know I have no nursing training. So I don't know
11 what standard of nursing documentation applies.

12 When I have reviewed 64B8-9.003, it has been
13 in regards to physicians licensed under 726 -- forgive
14 me a minute -- the statutes that create licensing for
15 physicians. Excuse me. 766.

16 Q. And do you think that nurses have a different
17 standard of care with regard to maintaining medical
18 records?

19 MS. WIDLANSKY: Form, asked and answered.

20 THE WITNESS: Dr. Silva, I've told you I'm
21 not a nurse. I'm not sure what -- I don't keep
22 up with nursing standards and nursing regulations
23 for the State of Florida.

24 I don't know that I know what the nurses are
25 obligated to do or not do or what they're

1 permitted or not permitted.

2 BY MR. SILVA:

3 Q. Did you ever supervise nurses in your career?

4 A. Yes.

5 Q. Are you familiar with what their duties and
6 roles are with regards to women who are pregnant with a
7 baby?

8 MS. WIDLANSKY: Form.

9 THE WITNESS: Yes.

10 BY MR. SILVA:

11 Q. Okay. And what setting are you familiar with
12 that, in the hospital or an outpatient setting?

13 A. All of the above.

14 Q. And would you be familiar with what their duties
15 are with regard to recordkeeping?

16 A. In a general way, yes.

17 Q. You think that's the standard of care for any
18 health care practitioner to maintain inadequate medical
19 records of their interaction with a patient?

20 A. To the standard of their profession, yes.

21 Q. And that, again, the same thing for if any late
22 entries are made to the medical record, time, dated, and
23 noted as a late entry?

24 A. Yes, sir.

25 Q. I want to go back to our emergency within

1 perinatal units exhibit. You should have it there.

2 A. I probably do. Just probably under my -- or
3 I may have returned it actually.

4 Q. I don't think you did.

5 A. I didn't? Okay.

6 MS. WIDLANSKY: I don't have the marked one.

7 THE WITNESS: I have the unmarked one. Are we
8 talking 1.5?

9 BY MR. SILVA:

10 Q. That's it.

11 A. Actually it is.

12 Q. It states here: The guidelines for a stat
13 C-section; you see that?

14 A. Yeah.

15 Q. Are there any guidelines there for an emergent
16 C-section?

17 A. No, but that's what we performed on
18 Ms. McCants.

19 Q. But there is no guideline on this protocol,
20 correct, for an emergent C-section?

21 MR. MITTELMARK: Form.

22 MS. WIDLANSKY: Form, asked and answered.

23 THE WITNESS: No, it's clearly labeled
24 emergencies within the perinatal units.

25 BY MR. SILVA:

1 Q. Does this document make any distinction for an
2 emergent C-section, as you have testified to today?

3 MS. WIDLANSKY: Form, asked and answered.

4 THE WITNESS: No.

5 BY MR. SILVA:

6 Q. Okay. Did you ever contact anyone in
7 administration at St. Mary's Medical Center and tell them
8 that they should include a guideline for emergent
9 C-sections?

10 MS. WIDLANSKY: Asked and answered.

11 MR. BLOOM: Form.

12 THE WITNESS: I have never contacted the
13 administration in terms of policies and
14 procedures relative to that issue.

15 BY MR. SILVA:

16 Q. Okay. With regard to a stat C-section OB
17 inhouse, does that mean to you that an obstetrician is
18 available somewhere in the hospital?

19 A. It doesn't mean that directly, but sometimes
20 there are OBs in the house.

21 Q. Okay. What do you think this guideline: Stat
22 C-section OB inhouse means?

23 MR. BLOOM: Form.

24 MS. WIDLANSKY: Join.

25 THE WITNESS: That means that in the event

1 that the obstetrician is physically present in,
2 you know, the confines of St. Mary's Hospital in
3 a stat Cesarean section is indicated, this may be
4 the procedure they ideally would like
5 implemented.

6 BY MR. SILVA:

7 Q. Did you ever tell any of the health care
8 providers involved in this case that a stat C-section was
9 ordered?

10 A. No.

11 Q. If the medical records state that a stat
12 C-section was ordered, do you have any explanation of how
13 that made its way into the medical record?

14 MS. WIDLANSKY: Form.

15 THE WITNESS: Now, you know there is not even
16 one iota of evidence that it says in that record
17 that Dr. Lopez ordered a stat C-section.

18 And I challenge you to show me that page so I
19 can see it. There is no way in the record that
20 says Dr. Lopez ordered a stat C-section.

21 BY MR. SILVA:

22 Q. We'll get to the stat C-section --

23 A. You're saying in a hypothetical? I can't
24 control what other people say in the medical record.

25 Q. What I want to know is if the medical records

1 state that a stat C-section was ordered -- I'm not saying
2 you ordered it -- I'm saying that it's in the medical
3 record that a stat C-section was ordered, do you know how
4 that got in the medical record? That's my question.

5 MS. WIDLANSKY: Form.

6 MR. BLOOM: Join.

7 THE WITNESS: I don't understand your
8 question. Could you show me where the medical
9 record?

10 BY MR. SILVA:

11 Q. We'll get to it.

12 A. Okay, if you show it to me I'll be happy to
13 answer your question. Otherwise, hypothetically, I
14 have no way to explain how anybody, other than myself,
15 what they said or did.

16 Q. I want you to assume for me that the medical
17 records show that a stat C-section was called. If you
18 didn't call it --

19 A. What? I'm sorry, I don't understand your
20 premise. Say it one more time.

21 In a hypothetical where a stat C-section was
22 called?

23 Q. Listen carefully.

24 A. Okay.

25 Q. I want you to assume for me --

1 A. Okay.

2 Q. -- that these medical records state that a stat
3 C-section was performed on Heather McCants.

4 A. Okay.

5 Q. If you didn't order it, do you have any
6 explanation for how a stat C-section got in the medical
7 records?

8 MS. WIDLANSKY: Form, asked and answered,
9 calls for speculation.

10 MR. BLOOM: Join.

11 THE WITNESS: No.

12 BY MR. SILVA:

13 Q. Did you order a stat C-section on Heather
14 McCants on January 26, 2011?

15 A. No.

16 Q. Do you know who did?

17 MR. BLOOM: Form.

18 THE WITNESS: Nobody.

19 BY MR. SILVA:

20 Q. Do you know if Dr. Sanches ordered a stat
21 C-section?

22 MR. BLOOM: Form.

23 THE WITNESS: I do not know because I have
24 not read her deposition, I have not spoken to
25 her, and I saw nothing in the medical record

1 from, when I reviewed it, indicating Dr. Sanches
2 order a stat C-section, or any C-section at all.

3 BY MR. SILVA:

4 Q. Did you review all the medical records with
5 regard to Heather McCants on January 26, 2011?

6 A. I read what I have, yes.

7 Q. Okay. And did you see that a stat C-section was
8 ordered anywhere in those medical records?

9 A. No doctor ordered a stat Cesarean section
10 anywhere in those records.

11 Q. Okay. Now, do you know why a stat C-section is
12 contained in the Rapid Response Team worksheet?

13 MR. BLOOM: Form.

14 MS. WIDLANSKY: Form.

15 THE WITNESS: You would have to ask the
16 author, who I believe where that was indicated,
17 were that author got it from.

18 BY MR. SILVA:

19 Q. Did you read Michelle Duane's deposition before
20 today?

21 A. I have not read anybody's deposition.

22 Q. Okay, so the answer is "no"?

23 A. Correct.

24 Q. Did you talk to Michelle Duane about Heather
25 McCants prior to today?

1 A. I've never talked to Heather -- I've never
2 talked to Michelle --

3 Q. Duane.

4 A. Duane.

5 Q. Do you know who Michelle Duane is?

6 A. No.

7 Q. You haven't met her before?

8 A. I can't say I haven't met her because I'm
9 around the hospital a lot. So, you know if I were to
10 run into her and recognize her, I may have said "hi"
11 in a hallway. But have I ever had a conversation with
12 her? Not to my knowledge, not to my conscious
13 knowledge I've ever seen her anywhere.

14 Q. Are you aware that she stated in two different
15 areas of the Rapid Response Team that a stat C-section
16 was called, and the O.R. was called?

17 A. I saw that, yes. Did I see that? Yes.

18 Q. The guidelines for a stat C-section here
19 states -- we'll get to it in a second, I'm just asking
20 you a question.

21 A. Okay.

22 Q. The guidelines for a stat C-section state here:
23 Call the main O.R. if anesthesia is not on the unit.

24 A. Correct.

25 Q. And why is that done?

1 A. Well, hypothetically if there's a stat
2 C-section you have to have anesthesia. And in order
3 to have anesthesia they're generally centralized out
4 of the main operating room.

5 In other words, if you are in the main
6 operating room at St. Mary's they have Spectralink,
7 which is like a telephone system. And they can
8 contact any anesthesiologist who is on premises by a
9 direct phone attached, you know in close proximity to
10 where that physician maybe or wherever they may be.

11 So if the anesthesiologist isn't around the
12 OB unit, you call the main O.R. and they will directly
13 punch you through to the anesthesiologist.

14 Q. Back in January 2011, did St. Mary's have
15 anesthesiologists designated for the obstetrics
16 department?

17 A. I can't say with certainty there was a
18 dedicated position, because I'm not positive about the
19 inner workings of anesthesia. But, in general, they
20 did have an assigned anesthesiologist for OB, both for
21 daytime and whoever was on-call at nighttime. And I
22 think they change shifts around five or six o'clock in
23 the afternoon.

24 Q. Did St. Mary's have an anesthesiologist named
25 Kerry Lane, M.D., on staff?

1 A. Yes.

2 Q. Do you know Dr. Kerry Lane?

3 A. Yes.

4 Q. And how do you know him?

5 A. As an anesthesiologist who primarily works in
6 the obstetrical unit during the day, Monday through
7 Friday.

8 Q. Have you performed a stat C-section at
9 St. Mary's Medical Center where Dr. Lane used general
10 anesthesia?

11 A. Yes. I believe so.

12 Q. Was that an emergent C-section?

13 A. No, it was a stat.

14 Q. Do you think that there's any difference in the
15 type of anesthesia that can be used in a stat C-section
16 versus an elective C-section?

17 MS. WIDLANSKY: Form.

18 MR. BLOOM: Form.

19 THE WITNESS: Do I believe as an obstetrician
20 that there is a difference in stat C-section
21 versus an elective C-section?

22 BY MR. SILVA:

23 Q. Yes, with regards to the type of anesthesia you
24 use.

25 A. Yes.

1 Q. And tell me what your understanding is.

2 A. The anesthesiologist is the only medical
3 doctor who has the knowledge, training, and ability to
4 determine which type of anesthesia is appropriate for
5 a clinical situation.

6 And that an obstetrician -- I mean you can
7 offer your opinion -- but ultimately the decisionmaker
8 will be the anesthesiologist.

9 Q. In your experience as an OBGYN where you had to
10 perform a stat C-section, was general anesthesia a
11 quicker method of obtaining anesthesia?

12 MR. BLOOM: Form.

13 THE WITNESS: Not always, no, because -- and
14 the thinking on that has changed quite a bit over
15 my career, because there may be cases where it's
16 safer to do a spinal anesthetic than to perform a
17 general endotracheal crash anesthetic.

18 BY MR. SILVA:

19 Q. That's not my question.

20 My question is: As an obstetrician on a patient
21 that you had to perform the stat C-section on, is general
22 anesthesia a quicker form of anesthesia then, say, an
23 epidural?

24 MR. BLOOM: Form.

25 THE WITNESS: Not necessarily.

1 BY MR. SILVA:

2 Q. In what circumstances can an epidural be quicker
3 than general anesthesia to get a patient into position
4 for a stat C-section?

5 MS. WIDLANSKY: Form.

6 MR. PUYA: Form.

7 THE WITNESS: If the level of anesthesia is
8 sufficient enough and dense enough for a
9 Caesarian section to be performed, there would
10 really be no need to waste time doing a general
11 on top of an appropriately anesthetized patient.

12 BY MR. SILVA:

13 Q. I understand. And that's assuming that the
14 patient already has an epidural in place, correct?

15 A. Correct.

16 Q. Assume the patient doesn't have an epidural in
17 place and requires a stat C-section. Is general
18 anesthesia a quicker form of getting the patient ready
19 for a stat C-section than having to go through the
20 process of performing an epidural and waiting for it to
21 take affect?

22 MR. PUYA: Form.

23 MS. WIDLANSKY: Form.

24 BY MR. SILVA:

25 Q. As an obstetrician.

1 A. As an obstetrician, sometimes yeah. But
2 there may be other factors where -- time is only one
3 of many elements that have to be taken into
4 consideration. If a patient just recently ate; if
5 there is an airway management issue, but in general I
6 would say yes.

7 Q. Okay. How long have you had your own practice?

8 A. That's kind of a loaded question, I think
9 I've always had my own practice.

10 I have worked with other doctors. I've owned
11 my own P.A. since 1998.

12 Q. And are you compensated in any way by St. Mary's
13 Medical Center for any of the services you provide there?

14 A. No.

15 Q. Do you take E.R. call?

16 A. No, I do not, not at St. Mary's.

17 Q. Okay. Did you ever take emergency room calls at
18 St. Mary's?

19 A. Yes, but I was never compensated for it. It
20 was part of every obstetrician's -- you know they
21 rotated E.R. call among all the obstetricians, it was
22 uncompensated.

23 Q. When did you stop taking E.R. calls at
24 St. Mary's?

25 A. When I think I hit 15 years of service and

1 that was the guideline for the medical staff.

2 Q. Since 1998 have you had any partners in your
3 practice?

4 A. Yes. I had, you know, I don't know if you're
5 talking the legal definition of partner I had employed
6 physicians under my P.A.

7 Q. When was the last time you did that?

8 A. I don't remember exactly. I would imagine
9 its been about eight years.

10 Q. Do you remember the name of that person, him or
11 her?

12 A. Yes, Dr. Felix Andarsio, A-N-D-A-R-S-I-O.

13 Q. Have you ever participated in the 24-hour OB
14 program at St. Mary's?

15 A. Yes, I started it.

16 Q. When did you start that?

17 A. December of 2000 -- no, December of 1990 as a
18 matter of fact. November or December of 1990.

19 Q. And why was that started?

20 A. Well, prior to that time it was a service for
21 delivery of unassigned patients that was coordinated
22 between physicians and nurse midwives.

23 And a decision was made to change covering
24 groups and the covering group -- there were four of us
25 that were directors of the new covering group. And

1 part of our agreement of the practice was that the
2 physicians needed to be in-house 24 hours a day. A
3 physician had to be in-house 24 hours a day.

4 And they were supplemented by a nurse midwife
5 that was in-house 24 hours a day.

6 Q. Why was that a decided that a physician needed
7 to be in-house 24 hours a day?

8 MR. PUYA: Form.

9 THE WITNESS: We felt the volume of activity
10 was sufficient enough that it would be prudent
11 not to have delays in initiating Cesarean
12 sections in case emergencies arose.

13 I don't think we were contractually obligated
14 to do that, but we felt it resulted in better
15 care.

16 BY MR. SILVA:

17 Q. Okay. And on the date of this incident,
18 January 26, 2011, do you know if a 24-hour OB was on
19 duty?

20 A. Well, again, I left that scenario in the
21 early 90's. It's my understanding that another
22 practice does keep a physician inhouse 24 hours, yes.

23 Q. Okay. Is that practice OBGYN Specialists of the
24 Palm Beaches?

25 MR. BLOOM: Form.

1 THE WITNESS: It may be that or a subsidiary
2 of that.

3 BY MR. SILVA:

4 Q. Have you ever had any dealings with that
5 practice, OBGYN Specialists of the Palm Beaches?

6 A. What do you mean by dealings? No, I have
7 never been a part of it. I have never contracted with
8 them.

9 Am I a congenial colleague to the physicians
10 of that practice? Yeah.

11 Q. Are they your competitors?

12 A. Yeah, in a sense they're my competitors, but
13 they're also colleagues, they're both.

14 Q. So again, my question is: Were you aware that
15 there was a 24-hour OB on duty on the date of this
16 incident, January 26, 2011?

17 A. I'm aware that another practice maintains a
18 physician for the benefit of their patients, and the
19 benefit of the patients that may be walk-ins or
20 emergencies at the facility, yes.

21 Q. And you were aware that that OB was available if
22 an emergent C-section needed to be performed?

23 MR. BLOOM: Form.

24 BY MR. SILVA:

25 Q. Correct?

1 A. Sure. If one of her patients or his patients
2 needed an emergent C-section they were available for
3 their practice, correct.

4 Q. Okay. Are part of the duties of the emergency
5 24-hour OB at St. Mary's to perform a C-section if
6 another OB is not available?

7 A. I don't know.

8 Q. You don't know what their duties are?

9 A. No, I'm not privy to them. I've never seen a
10 policy or procedure or contract or an agreement.

11 I don't know within the OB department that we
12 have ever reached that kind of -- this is a competing
13 practice that happens to have a quantity of patients
14 that they feel it's necessary for them to keep an
15 inhouse OB.

16 Q. Have you ever in your entire career asked
17 another OB to perform a stat C-section on one of your
18 patients because you couldn't get to the hospital on
19 time?

20 A. No.

21 Q. Never?

22 A. Not that comes to mind, no.

23 Q. Would you consider that to be within the
24 standard of care that if an OB couldn't make it to the
25 hospital in time to perform a stat C-section on one of

1 their patients if they needed it, that another OB could
2 perform that procedure?

3 MS. WIDLANSKY: Form.

4 MR. BLOOM: Form.

5 THE WITNESS: Yeah, sure. I would have no
6 problem asking someone or be asked by someone,
7 no.

8 BY MR. SILVA:

9 Q. Right. Do you know if there is any policy at
10 St. Mary's Medical Center that requires a patient who
11 needs a stat C-section if the patient's attending OB is
12 not available for the nurses to call for any available OB
13 to perform that procedure?

14 MR. MITTELMARK: Object to form.

15 MS. WIDLANSKY: Join.

16 MR. BLOOM: Join.

17 THE WITNESS: Yes, the item that -- is that
18 labeled number one?

19 BY MR. SILVA:

20 Q. Yes, sir.

21 A. Yes, Exhibit Number 1 is entitled:
22 Emergencies within perinatal units.

23 Q. Okay. Where on this does it state that if an OB
24 is not available to perform a stat C-section on their
25 patient that any available OB can do that?

1 A. Repeat that question one more time.

2 Q. Yeah. Where on this sheet does it state that if
3 an OB is not available to perform a stat C-section on
4 their own patient, that any available OB can do that?

5 A. I don't know that it says that in that
6 terminology, but it seems like category C under
7 guidelines, number 2, guideline C, 2C.

8 THE VIDEOGRAPHER: Can we change tapes real
9 quick?

10 MS. WIDLANSKY: Actually I would like a
11 break.

12 MR. SILVA: Let's take a five minute break.
13 (Break in the proceedings)

14 THE VIDEOGRAPHER: We are now back on the
15 video record at 3:40. This is the beginning of
16 tape 2.

17 BY MR. SILVA:

18 Q. Sir, take a look at that emergency C-section
19 protocol document we were referring to earlier.

20 Referring to guidelines, Roman numeral II,
21 letter C, is this a scenario where the nursing staff can
22 call for any available OB, if they feel the need to do
23 so?

24 A. Yes.

25 Q. Okay. Do you know if Patrick Hare or Janice

1 Duckworth called for any available OB prior to the Rapid
2 Response Team being called on January 26, 2011?

3 MR. MITTELMARK: Object to the form.

4 MS. WIDLANSKY: Join.

5 MR. BLOOM: Join.

6 THE WITNESS: No.

7 BY MR. SILVA:

8 Q. And it states here in this guideline: When in
9 the opinion of a perinatal nursing staff determines an
10 emergency arises and the primary physician is not
11 inhouse, they can do that for fetal and/or maternal
12 distress, right?

13 A. Yes.

14 Q. Now, were you in the hospital at approximately
15 3:05 in the afternoon on January 26, 2011?

16 A. No.

17 Q. Where were you?

18 A. I was at Good Samaritan Medical Center.

19 Q. Okay. And what were you doing at Good Samaritan
20 Medical Center?

21 A. I believe I was finishing rounds.

22 Q. So, according to this protocol if there's fetal
23 or maternal distress and the nurses needed to speak to
24 you and they couldn't get a hold of you, they could call
25 for any available OB inhouse, correct?

1 A. Yes.

2 Q. Do you know if the nurses attempted to call you
3 at any point in time prior to the Rapid Response Team
4 being called?

5 A. I do not know.

6 Q. Can you tell us when anyone from St. Mary's
7 contacted you regarding Heather McCants and her baby's
8 condition on January 26, 2011?

9 A. I can't tell you with the specificity of the
10 exact time or moment, but I remember speaking -- I had
11 a beeper back then -- I remember my beeper went off.
12 I was at Good Sam. I was actually leaving Good Sam.
13 I went back to the nurses' station and called Anna
14 Pardon, which is Turner 2 South and spoke with Nurse
15 Duckworth.

16 Q. You spoke with Nurse Duckworth herself?

17 A. Well, a clerk answered the phone and they
18 either patched me through her Spectralink, or she came
19 to a phone, I don't know where she was, I don't know
20 if she was in the room or somewhere else.

21 Q. Sure. But you spoke with her personally?

22 A. Yeah.

23 Q. Did you speak with anyone else beside Nurse
24 Duckworth that day?

25 A. Initially someone else answered the phone and

1 then either connected me through a Spectralink or
2 connected me to her phone.

3 Q. Sure. But with regards to any medical issues of
4 Heather McCants or her baby, did you speak with anyone
5 else beside Nurse Duckworth?

6 A. On that call?

7 Q. Yes.

8 A. No.

9 Q. Let's get back to what was the process for
10 getting ahold of you by St. Mary's.

11 Could they call you on your cell phone?

12 A. In general, I asked them to use my beeper
13 because there was better penetration in the various
14 hospitals that I go to, since some of the hallways and
15 some of the rooms are lined with lead. So cell phone
16 signals are iffy at that time in the facilities.

17 So I had a beeper and a cell phone, but I
18 always asked them to use my beeper first.

19 Q. Did your beeper have any specific phone number?
20 Did they have to dial any number to get ahold of you
21 through your beeper?

22 A. Yes.

23 Q. What was it?

24 A. Area code 561.937.8684.

25 Q. 8684?

1 A. Yes.

2 Q. And do you know how records are kept of any
3 phone calls that you get to that beeper, back in January
4 of 2011?

5 A. I don't think any records were kept.

6 Q. What carrier did you have this phone number
7 through?

8 A. I don't really remember because, you know,
9 when I pay the bills I never really paid attention.

10 Q. Did you pay the bills through your practice?

11 A. Yes.

12 Q. Okay --

13 A. We could find out, I just don't know as we
14 sit here today.

15 Q. Right. I mean, you could go back and find out
16 who the carrier was?

17 A. Yeah.

18 Q. Do you know if it was the same carrier as your
19 cell phone?

20 A. No, it was not AT&T.

21 Q. Could you do that and find out who the carrier
22 was --

23 A. Yeah.

24 Q. -- and provide that information to your attorney
25 and I'll request it.

1 A. Sure.

2 Q. Besides your hospital practice did anyone else
3 reach you on your beeper?

4 Did you ever give that out for any personal
5 reason?

6 A. I'm not sure I understand your question,
7 could you repeat it.

8 Q. Yeah, I mean, was your beeper used primarily for
9 your job as an obstetrician?

10 A. Yes.

11 Q. Okay. So any phone calls that you would have
12 gotten to your beeper, more likely than not, would have
13 been from a health care provider regarding a patient?

14 A. Or my office, right.

15 Q. Do you have any recollection of what time you
16 got that beeper call on the 26th?

17 A. I remember that it was after 15:00, it was
18 after three o'clock. And like I said, I was just
19 about to leave Good Sam, and because I went back to
20 the nurses' station and called in.

21 Q. How long did it take you to get back to the
22 nurses' station to make the phone call after you were
23 notified on your beeper?

24 A. Oh my gosh, however long it takes to walk
25 about ten feet, turn around and walk ten feet.

1 Q. And then how did you know what number to call
2 from your beeper call? Does the number come through?

3 A. Yes. The beeper was a numeric beeper. I
4 know this sounds ancient. You would have to punch in
5 the number and hit the pound sign, and that number
6 would flash on my beeper.

7 Q. Do you recall what number you got the phone call
8 from?

9 A. I don't recall the number, but it had to have
10 been 22741 because that's where Nurse Duckworth was
11 and that's where my patient was.

12 Q. Is that antenatal unit at St. Mary's?

13 A. Yes.

14 Q. When you say 22741, is there a three digit
15 number before that?

16 A. If -- most of the nurses would punch in 22741
17 because they think you're in the hospital.

18 Q. Okay.

19 A. But sometimes they would do the whole
20 numeric, 881.2741. When I say "they" could be them or
21 the clerk.

22 Q. Right. When you got -- when you returned the
23 phone call did you have any trouble getting through?

24 A. No.

25 Q. Okay. Who was the first person you spoke with

1 at St. Mary's?

2 A. An unidentified voice. I don't know who it
3 was.

4 Q. Do you know if it was a clerk or RN or someone
5 else?

6 A. I don't know who it was. I don't recall
7 exactly who it was.

8 Q. Do you recall what you said to that person?

9 A. Somebody looking for me.

10 Q. Okay. Do you recall what they said to you?

11 A. Yes.

12 Q. What did they say?

13 A. They said yes.

14 Q. Okay. And what did you say in reply?

15 A. They put me on whatever it is, that transient
16 hold, and then I was immediately connected to --
17 either Duckworth picked up or it was transferred up to
18 her Spectralink. But she literally almost immediately
19 picked up.

20 Q. When you say "Spectralink," what does that mean?

21 A. That telephone -- a telephone system you can
22 patch through a landline phone to wherever the person
23 is that has that phone.

24 Q. Are those the Motorola phones that were provided
25 to employees at St. Mary's at the time?

1 A. I don't know the brand, okay, but it's a
2 phone, yeah, they carry the phone like you would carry
3 a cell phone now, you know. And they would attach it
4 to, I imagine, their waistband or whatever. And it
5 was stuck to the person's you know, body, or in close
6 proximity to the body so if the phone rang they would
7 pick it up and answer it.

8 Q. And when Janice Duckworth answered the phone, do
9 you recall what she said to you?

10 A. Yeah. I mean not word-by-word but the gist
11 of it was, you know, Ms. McCants had a respiratory
12 arrest. And Rapid Response was called. And the
13 baby's heart rate went down, and it appears to be
14 coming up.

15 Q. Do you recall if she said anything else to you
16 besides that?

17 A. Those were the elements that I have
18 independent recollection.

19 Q. Okay. Did you say anything to her?

20 A. Yeah. I said, let's get her ready for an
21 emergent C-section. I'm at Good Sam and on my way.

22 Q. Did Nurse Duckworth tell you that Heather also
23 experienced abdominal pain?

24 A. Not at that time, no.

25 Q. Did Nurse Duckworth tell you that Heather

1 McCants desaturated?

2 A. Yes, because -- well, I believe what she told
3 me -- I can't remember specifically. Let me back up.

4 I don't have an independent recollection of
5 the desaturation, but whatever she told me the first
6 thing I thought of is pulmonary embolism.

7 Q. And at that point did she tell you that
8 Dr. Sanches was in the room?

9 A. No.

10 Q. At that point did you know one way or the other
11 if the Rapid Response Team had been called?

12 MR. BLOOM: Form.

13 THE WITNESS: Yes.

14 BY MR. SILVA:

15 Q. You knew that?

16 A. Yeah. She said Rapid Response was here. You
17 know, the heart rate is back up. You know, whatever
18 her vital signs were, I believe.

19 Q. So, no one told you that Dr. Sanches was in the
20 room?

21 MR. BLOOM: Form.

22 BY MR. SILVA:

23 Q. Correct?

24 A. I don't recall. I have no independent
25 recollection of Dr. Sanches' name being bantered

1 around.

2 Q. Do you recall if you asked if any OB was in the
3 room and responding to the Rapid Response Team call?

4 A. No.

5 Q. Did you request to speak to the OB in the room?

6 A. No.

7 MR. BLOOM: Form.

8 BY MR. SILVA:

9 Q. Do you know if any of the OBs in the room
10 requested to speak to you?

11 A. No.

12 Q. Have you ever been involved in a Rapid Response
13 Team call at St. Mary's?

14 A. Yes.

15 Q. On how many occasions?

16 A. I don't know.

17 Q. More than ten?

18 A. You know, I've been doing this a long time, I
19 just don't recall how many times. Probably less than
20 ten times, probably less than five.

21 Q. And you were the OB in that circumstance?

22 A. I was an OB that was in the hospital at the
23 time, correct.

24 Q. Okay. Is it your understanding that the Rapid
25 Response Team for the OB floor requires an OB to be part

1 of the team?

2 MR. BLOOM: Form.

3 MS. WIDLANSKY: Join.

4 THE WITNESS: Whether it does or doesn't I
5 would respond anyway. I don't know what the
6 actual requirements are, but if there's somebody
7 on any of the maternity floors and it may involve
8 a pregnant patient, as an obstetrician I respond.

9 BY MR. SILVA:

10 Q. After you received the phone call and you
11 returned the phone call did you say anything else to
12 Janice Duckworth after what you just told me?

13 A. No, not that I can recall.

14 Q. Did you tell Janice Duckworth to call the
15 operating room?

16 A. No, because I did that myself.

17 Q. Did you tell Janice Duckworth to call the
18 anesthesiologist or OB?

19 A. No, because he was in the OB O.R. at the
20 time.

21 Q. Did you call the operating room and tell them
22 that an emergent C-section had been called by yourself?

23 A. I called the OB operating room and told them
24 that I was calling an emergent Cesarean section.

25 Q. Who did you talk to?

1 A. I don't recall.

2 Q. What did that person say to you?

3 A. We are finishing up a case and we'll get the
4 room ready.

5 Q. How many OB operating rooms are contained at
6 St. Mary's?

7 A. Well, we have two on the obstetrical floor
8 and we have the availability of every operating room
9 in the main O.R., if there is overflow.

10 Q. Did anyone tell you that there was another case
11 going on in the second OB room?

12 A. No.

13 Q. So, it was your understanding there was one case
14 going on in the OB operating room?

15 A. Correct.

16 Q. Do you know how many OB anesthesiologists were
17 on duty that day?

18 A. No.

19 Q. Do you know if St. Mary's keeps more than one
20 anesthesiologist inhouse in case that two OB operating
21 rooms need to be ready at the same time?

22 A. During the day what I'm aware of is that
23 during that time period Dr. Lane was primarily there
24 almost everyday, unless he was on vacation, on the OB
25 floor.

1 And that they always seemed to have the
2 availability of literally every anesthesiologist that
3 was in the house that day. So whatever, they always
4 had a backup anesthesia for OB. They always had a
5 third anesthesia for OB.

6 Now, I don't know how many anesthesiologists
7 they kept in the main O.R. or out in the Kimmel
8 Center, but there was like a domino -- a never-ending
9 number -- I never ran out of anesthesiologists, let me
10 just put it that way.

11 Q. There would never be a reason to delay an
12 emergent stat C-section because there's a lack of
13 anesthesiologists at St. Mary's; is that fair?

14 MR. MITTELMARK: Object to the form.

15 THE WITNESS: In general, the anesthesia team
16 was -- I was never not able to have an anesthesia
17 team.

18 BY MR. SILVA:

19 Q. Did anyone tell you that there was no
20 anesthesiologist available to perform the type C-section
21 you wanted to perform?

22 MR. PUYA: Form.

23 THE WITNESS: No.

24 BY MR. SILVA:

25 Q. Do you know if Dr. Lane was the anesthesiologist

1 in the other operating room?

2 A. Yes.

3 Q. Did Dr. Lane come and talk to you on the phone
4 about the patient's condition?

5 A. No.

6 Q. Did you ever have any conversations with
7 Dr. Lane regarding Heather McCants, or her baby, prior to
8 coming into the operating room before you performed the
9 procedure?

10 A. Yes, because when I arrived -- you know, Good
11 Sam and St. Mary's are like two miles apart and it
12 takes five to seven minutes, maybe ten minutes
13 depending on the lights.

14 When I got to the OB O.R. I stuck my head in
15 because they were still working on finishing up the OB
16 case that was in progress. And I told them we had an
17 emergent Cesarean section to follow.

18 Q. What time did you do that?

19 A. I don't know exactly. I would say based on
20 the note that I wrote probably before -- let's see,
21 this note was timed as 3:20 p.m., so before 15:20 p.m.

22 Q. So it's your testimony that you were in the
23 hospital before 3:20 p.m. on January 26, 2011?

24 A. Correct.

25 Q. At St. Mary's?

1 A. Yes.

2 Q. Okay. Now, is the note that you're referring to
3 a handwritten note?

4 A. Yes, these are not Bate stamped, but it looks
5 like this.

6 Q. I have it, yes.

7 A. Okay.

8 Q. Did you write any other notes besides that one
9 prior to performing the C-section on Heather McCants?

10 A. I wrote the consent form, but that wasn't
11 really a note.

12 Q. So beside --

13 A. I signed it. Filled it out and signed it.

14 Q. Beside that progress note, did you write any
15 other notes in the medical record?

16 A. No.

17 MR. SILVA: I'm going to mark this document
18 as plaintiff's Exhibit Number 5. There you go,
19 sir.

20 (Plaintiff's Exhibit No. 5 was marked for
21 identification)

22 BY MR. SILVA:

23 Q. Is that the note that you're referring to?

24 A. Yes.

25 Q. Now, I want you to take your time, and I'll find

1 my copy.

2 I want you to read that note into the record and
3 do it in a way that the court reporter can get it down.

4 A. "January 26th of '11, 3:20 p.m. On-call
5 note. Call because patient had respiratory arrest.
6 Upon administration of medication to clear PICC line.
7 Baby had approximately ten minute deceleration.
8 Patient has tachycardia with concerns about possible
9 pulmonary embolism. Hospitalist, Jumapao called.
10 Recommend Cesarean section delivery. Pros, cons,
11 benefits. Patient transferred to labor and delivery."

12 Q. Okay. When you wrote this note had you examined
13 Heather McCants previously?

14 A. Previous to this note, like in the immediate
15 previous --

16 Q. Yes.

17 A. -- or previous like days before?

18 Q. No, no. After she had the reaction to the
19 Cathflo that was administered at 3:05 p.m., prior to 3:20
20 did you examine her?

21 A. Prior to 3:20?

22 Q. Yes.

23 A. I don't know.

24 Q. If you had would you have documented that in the
25 medical records?

1 A. Not necessarily, because this was basically a
2 disposition note.

3 Q. Okay. So, is it your practice to document in
4 the medical record any time you lay your hands on a
5 patient?

6 A. Well, to the best of my ability. I mean, if
7 I'm in an emergent situation I may not document
8 because I may be interested in getting the patient
9 ready to do a procedure.

10 Q. Is that the reason why you didn't document that
11 you may have examined her, because you were trying to get
12 her to the operating room to get her baby out as soon as
13 possible?

14 A. Well, that may be one of many explanations.

15 Q. But that could be an explanation, right?

16 A. That could be one, but there could be more or
17 less to that explanation.

18 Q. Do you have any recollection as you sit here
19 today of any examination that you did on Heather McCants?

20 A. On this day and time?

21 Q. Yes.

22 A. No.

23 Q. Do you have any recollection of any fetal heart
24 monitor strips that you looked at?

25 A. Yes.

1 Q. What's your recollection of that?

2 A. I looked at, and I see there's a copy of it
3 here, the fetal heart strips from around 15:00 on --

4 Q. I'm talking about outside of the medical
5 records, just off the top of your head recollection?

6 A. Do I have an independent recollection?

7 Q. Yes.

8 A. I have independent recollection I looked at
9 the strips. I don't have an independent recollection
10 of everything I saw on the strips.

11 Q. And you did that before you started the
12 procedure, right?

13 A. Yes.

14 Q. Are you aware that you read this note at 3:20
15 and the baby wasn't taken out until 3:52?

16 A. Yes, I'm aware of that now, yes.

17 Q. At this point had the C-section been already
18 called?

19 A. Yes.

20 Q. And that was an emergent C-section?

21 A. Correct.

22 Q. Now, when you write: Called because patient had
23 respiratory arrest upon administration of -- advice to
24 clear PICC line?

25 A. Upon administration of medications --

1 Q. Medications?

2 A. -- to clear PICC line.

3 Q. Where did you gain that information from?

4 A. Nurse Duckworth.

5 Q. Did you have any additional conversations with
6 Nurse Duckworth before you read this note after that
7 phone call?

8 A. Yes.

9 Q. And did she add anything in any conversations
10 that you included in this note besides the phone call you
11 had with her?

12 A. No.

13 Q. Do you have any recollections of how many
14 conversations you had with Nurse Duckworth before you
15 read this note after the phone call?

16 A. After the first phone call there was a second
17 phone call, that happened after this note asked
18 where's the patient, and how is the patient doing.
19 Something along those lines.

20 Q. That second phone call, did you initiate it or
21 were you called?

22 A. No, I called.

23 Q. Do you recall what time the second phone
24 occurred at?

25 A. No.

1 Q. Was before 3:20?

2 A. No, it was after.

3 Q. How does that work?

4 A. I called to see where the patient was because
5 the patient wasn't in the operating room area.

6 Q. Okay.

7 A. So, I wanted an updated report of where the
8 patient was.

9 Q. Where were you when you made that second phone
10 call?

11 A. From outside the operating room there is a
12 little phone station there, little nurses -- kind of
13 like a mini desk station.

14 Q. Do you recall what time you made that phone call
15 at?

16 A. No.

17 Q. It was after 3:20 though, but before the
18 delivery?

19 A. Correct.

20 Q. Were you concerned about where the patient was?

21 A. Yeah. I wanted to know whether they were in
22 the process of bringing the patient down.

23 Q. And who did you talk to when you made that phone
24 call?

25 A. Ultimately Nurse Duckworth.

1 Q. And what did she tell?

2 A. She gave me a status report.

3 Q. Do you recall what she told you on the second
4 phone call?

5 A. No, not specifically. I don't have an
6 independent recollection of everything she said.

7 Q. When you arrived at the hospital did you go up
8 and see Heather McCants?

9 A. No.

10 Q. Where did you go?

11 A. I went to the operating room, to the
12 obstetrical operating room to get things going.

13 Q. Okay, you went straight to the operating room?

14 A. Correct.

15 Q. And it was your assumption that the patient was
16 going to be brought down to the operating room so you
17 could perform the C-section?

18 A. Well, that in fact is what happened.

19 Q. Okay. So, why did you make that second phone
20 call?

21 A. Because I wanted it faster. And I wanted --
22 if there was some issue upstairs that was delaying
23 that I also wanted to be sure that if I needed to be
24 up there rather than down there that I was up there
25 rather than down there.

1 I mean, I was concerned about Ms. McCants and
2 I knew the team was doing the best they can to get her
3 in there timely, but you know, if there was some issue
4 that came up because they were in the middle of
5 another intervention I certainly was going to be
6 proactive and find out what it was and see what I
7 could do to expedite it.

8 Q. Were you concerned about her baby too when you
9 made that second phone call?

10 A. Of course.

11 Q. Did you ever leave the area of the operating
12 room after you arrived at St. Mary's before you performed
13 the C-section?

14 A. Yes. I went to the elevator bank because I
15 was going to go upstairs.

16 Q. Elevator bank?

17 A. You know, elevators, they have three -- a set
18 of three elevators, and another set of three
19 elevators.

20 I went to the first set of three elevators
21 and I was going to go upstairs myself to see what I
22 could do to move things along.

23 Q. Okay. What floor is the OB operating room on?

24 A. First floor.

25 Q. And is that the operating room you went to?

1 A. Correct.

2 Q. You didn't go to the main operating room?

3 A. Correct.

4 Q. And when you arrived at St. Mary's, was the
5 procedure in one of the OB operating rooms still in
6 process?

7 A. Yes. I stuck my head in the room, saw
8 Dr. Lane, saw the patient, saw the nurses. They were
9 aware we were going to do a C-section.

10 And then I went to the other room, there's
11 two C-section rooms. The C-section room that was
12 unoccupied and I moved some of the equipment.

13 They have these aluminum, square aluminum
14 boxes where instruments are kept. Sometimes they're
15 kept, you know, after they're used they're usually
16 stored in there and they're taken down to wherever
17 sterilization happens.

18 So, I kind of moved some equipment around to
19 facilitate the transfer of the patient and saw the
20 room had been mopped and all that. And I may have
21 pulled my gloves -- probably pulled my gloves and gown
22 because I'm kind of a big guy and you know I always
23 have to get my gown.

24 Q. Did you tell Dr. Lane that this was an emergent
25 C-section?

1 A. Yes.

2 Q. So, did he hear you?

3 A. I can't speak for -- you know, a lot of
4 things are happening in an emergency room. Somebody
5 sticks their head in they usually listen to whatever
6 they say.

7 Now, I can't speak for Dr. Lane. He looked
8 at me so I assume he heard what I said. He nodded.
9 He didn't not hear what I had to say. I mean, you've
10 been hearing what I have to say.

11 Q. Sure. Why did you go to the elevator bank?

12 A. Well, because after the call I made to Nurse
13 Duckworth I was kind of anxious to get this case
14 going.

15 So I went to the elevator bank and the door
16 opens and, Laurie, I forgot what her last name is, the
17 Director of OB came out and she told me that they're
18 on their way.

19 Q. When you said Laurie, are you talking about
20 Laurie Monte (phonetic)?

21 A. Yes. If I masticate her name I'm going to be
22 -- I'm fried because I'm on video, but I know her as
23 Laurie. She is the Director of Maternal Fetal.

24 The door opened, it was the first elevator of
25 the three, she was coming out because she had been on

1 the second floor helping Ms. McCants get ready. And I
2 said, what's going on. She said they're coming right
3 down. That was that.

4 So I turned around and badged back into the
5 OB O.R. area.

6 Q. Who else was on the elevator with --

7 A. She was by herself, nobody else.

8 Q. At that point you went back to the operating
9 room?

10 A. Correct.

11 Q. Did you notify any of the nurses in the
12 operating room that this was an emergent C-section?

13 A. They knew that from the first time -- I did
14 not re -- I did that one time when I stuck my head in.
15 Told the nurses, they looked at me nodding their heads
16 acknowledging they were finishing up and that they
17 would prepare the next room, and so forth.

18 Q. Was there more than one team to perform an
19 emergent C-section available at St. Mary's that day?

20 A. I don't know.

21 Q. Well, what nurses were in the operating room
22 where the procedure was going on with Dr. Lane?

23 A. I remember Milsa and Barbara A-K-A-N, Akan.

24 Q. How about Nurse Braga?

25 A. She was somewhere. Yeah, I think she might

1 have been the circulator. She was there as well.

2 She's there during the daytime.

3 That was it. Those were the three that come
4 to mind.

5 Q. Right. So those nurses were doing the procedure
6 that was going on in one of the OB rooms, right?

7 A. Correct.

8 Q. Did you ever ask for another team to be
9 available so that you could perform the emergent
10 C-section as soon as possible?

11 A. No.

12 Q. Do you know when that first OB O.R. procedure
13 finished at?

14 A. No.

15 Q. Did the first OB O.R. procedure have to finish
16 before you started the emergent C-section on Heather
17 McCants?

18 A. Not necessarily.

19 Q. Well, my point is was it the same crew that was
20 in the operating room in the first OB O.R. that was used
21 for the procedure you performed on Heather McCants?

22 A. I believe it was the majority of them, if not
23 all of them, because someone would have had to recover
24 the patient that just had the Cesarean section.

25 Q. Okay. Do you know what type of procedure was

1 being performed in the other operating room when you
2 arrived?

3 A. Yes, it appeared to be a regular Caesarian
4 section.

5 Q. Just a routine Caesarian section?

6 A. I can't speak to the category of Cesarean
7 section, but what I mean by regular, it was like -- it
8 was not like a complicated Cesarean section.

9 It seemed like -- I saw the baby out, the
10 placenta out, and they appeared to be sewing up. So
11 they were at the finishing end of a regularly
12 performed Caesarian section.

13 Q. Do you recall how long after you came back from
14 the elevator bank you waited until Heather McCants
15 appeared?

16 A. No, I did not record times.

17 Q. Did you lay eyes on Heather McCants before she
18 was -- her baby was delivered in the operating room?

19 A. Yes. I spoke to her in the area that -- in
20 that area where the nurses -- mini nurses' station is
21 located when she arrived.

22 Q. When she arrived, is that like a pre-op holding
23 area?

24 A. You could call it that, I don't think -- it's
25 really a hallway that leads into two operating rooms

1 and outside the operating room there are two wash
2 basins.

3 Q. At that point when you first saw Heather, were
4 you scrubbed and ready to perform the surgery?

5 A. No.

6 Q. What did you do next?

7 A. I spoke to Ms. McCants. I got her to sign a
8 consent form. I explained to her the pros and cons
9 and the risk of benefits of surgery, why we were doing
10 this.

11 I reviewed her chart. I reviewed her medical
12 records that were available. Reviewed the strips that
13 were available.

14 Q. So her chart came with her?

15 A. Yes.

16 Q. Do you know if she already had an informed
17 consent signed for a C-section?

18 A. No. I do know, the answer is no.

19 Q. She did not?

20 A. She had signed it, but it had not been signed
21 by a surgeon. So another one was generated by me,
22 handwritten by me, and she signed it and it was
23 witnessed in the usual manner.

24 Q. Is there any reason why you just didn't sign-off
25 on the first consent form that she signed all the way

1 back on January 12th for the C-section, to save time?

2 A. It's my custom to be specific if I'm going to
3 do a Cesarean section. So it's not uncommon for me to
4 generate a Cesarean section form when I in fact am
5 going to a Cesarean section for -- you know, it's
6 always suspect if you tell someone, here, I want you
7 to sign a consent form that covers a blanket of every
8 possibility. And then it gets confusing as to whether
9 that possibility was entertained at the time of the
10 initial signature or the time that the procedure is
11 actually performed.

12 In order for clarity I generally -- if I'm
13 going to do a Cesarean section you will sign a fresh
14 form the day of the procedure, and you'll get a clear
15 explanation as to the why.

16 Q. Okay. So, you felt that you needed to do that,
17 you had the time to do that, even though that another
18 consent form for a Cesarean section was already signed on
19 the chart, you felt you needed to do that?

20 A. Took very little time. 30 seconds at most.

21 Q. 30 seconds. Did Heather McCants have any
22 questions for you?

23 A. I recall we had a conversation, but I don't
24 recall what -- I don't have an independent
25 recollection of what the exchange was about.

1 It seemed like she understood because
2 obviously she was there for the rapid response.

3 Q. Did Heather McCants read the document?

4 A. Yes, appeared she did.

5 Q. I mean, did you sit there and wait until she
6 read the document before you signed-off on it?

7 A. It wasn't that kind of a read. It's more
8 like, okay, and signed it. But she looked at it. I
9 can't speak to her ability to read.

10 Q. Then you state on this on-call note: The baby
11 had approximately a ten minute deceleration. Do you see
12 that?

13 A. Yes.

14 Q. Where did you gather that information from?

15 A. From Nurse Duckworth. And it was confirmed
16 later when I saw the strips myself.

17 I actually think I counted maybe nine minutes
18 or something. Before recovery. Now, it wasn't down in
19 fifties or sixties for nine minutes. It was down in
20 the fifties, sixties for an indeterminate amount of
21 time.

22 And then there's a rise you know, into the
23 normal range, which is 110 or more. And then you
24 know, a little bit of an over rise thereafter.

25 Q. And then you state here: The patient has

1 tachycardia with concern about possible pulmonary
2 embolism. Right?

3 A. That's the mother, correct, Ms. McCants.

4 Q. Okay. And beside yourself did anyone entertain
5 a differential diagnosis of the pulmonary embolism?

6 A. Yes.

7 Q. Who?

8 A. The hospitalist, Dr. Jumapao, when I gave her
9 the clinical presentation thought there is a
10 possibility among many things that could have caused
11 the respiratory arrest or respiratory issues, that
12 pulmonary embolism was one of the differential
13 diagnoses.

14 And she was in agreement to come in and
15 evaluate the patient for possible pulmonary embolism.

16 Q. Did Dr. Jumapao do that before the C-section or
17 after?

18 A. After.

19 Q. Did the pulmonary embolism being in the
20 differential in any way delay this emergent C-section?

21 A. No. I mean, other than the possibility in a
22 more perfect world I had to call the hospitalist, who
23 was an internal medicine physician to alert them I
24 needed an emergency consultative notes -- emergency
25 consultative services because I had a patient who may

1 have sustained one of many possible differential
2 diagnoses. It was included: Rule out pulmonary
3 embolism.

4 Q. Did anyone ever tell you they thought Heather
5 McCants had an allergic reaction to the Cathflo?

6 A. Yes, absolutely.

7 Q. Who?

8 A. I believe it was Nurse Duckworth said while
9 her diagnosis was uncertain, that in a nursing
10 assessment point of view that many things could have
11 happened, including a reaction -- not necessarily an
12 allergic reaction, but a reaction to Cathflo because
13 it seemed to be temporally related to when the
14 respiratory code was called.

15 Q. Did you ever conclude that the respiratory
16 arrest could have been caused by an allergic reaction to
17 the Cathflo?

18 A. Well, it was certainly on the differential
19 diagnosis. However, you know, in a differential
20 diagnosis you make a list of several things it could
21 be.

22 It could have been a reaction to Cathflo or
23 an allergic reaction to Cathflo. In an obese patient
24 who has been on bedrest for premature rupture of
25 membranes it could septic emboli from the fetal

1 placental uterine units.

2 She could have had a DVT. She could have had
3 -- there are many things that could have caused an
4 acute respiratory arrest. And certainly, you know,
5 she had also a previous history of cardiac
6 tachycardia, the mother. So there are multiple things
7 it could have been.

8 Q. On your differential list was a reaction to
9 Cathflo causing the respiratory arrest higher or lower
10 than your differential of pulmonary embolism?

11 A. To me it was lower because, as I recall, she
12 had Cathflo before without reaction. Now, a lot of
13 things can happen as a cause and effect, and some can
14 be as a coincidental.

15 For an example, it could have been
16 coincidental that Cathflo had been administered, but
17 the actual underlying cause could have been more
18 serious, like a pulmonary embolism. So we need to
19 rule that out fairly quickly to save the life of
20 Ms. McCants if she had an acute pulmonary embolism.

21 Q. Who told you Heather McCants had Cathflo prior
22 to this occasion?

23 A. Nobody told me that. But, I may be wrong on
24 that issue, but I remember I looked back to see -- I
25 think -- I thought she had Cathflo before because I

1 saw an order for Cathflo on a different date, if I
2 wasn't mistaken. Now, I don't know if that's
3 maintenance for Cathflo, you know, to keep the
4 catheters open or not.

5 Q. Did you think that she had Cathflo on a prior
6 occasion make you list a reaction to the Cathflo lower on
7 the differential diagnosis?

8 A. Again, that thought process occurred after
9 the Caesarian section.

10 My thought process was it was unknown the
11 actual cause of her need for a rapid response. My
12 gravest concern was if she had a pulmonary embolism
13 that we need to do testing that is not possible while
14 the patient is pregnant.

15 Furthermore, the baby had sustained an
16 abnormal fetal heart rate abnormality. And
17 furthermore, the mother's status had changed with a
18 maternal pulse that was heretofore much lower, and now
19 it's in the 150's up to 160's during the procedure,
20 during the C-section.

21 And that was also consistent with a possible
22 pulmonary embolism. You may get tachycardia, maternal
23 tachycardia if the mother's had a pulmonary embolism.

24 Q. Did you know if Heather McCants had any prior
25 medical history of maternal tachycardia?

1 A. Yes, in the past.

2 Q. So it wouldn't surprise if you she had
3 tachycardia, would it?

4 A. Well, one thing is there is tachycardia and
5 there is tachycardia. Okay?

6 If we are talking about she had some episodes
7 where her pulse was a little bit over a hundred beats
8 per minute, yes. Had she ever demonstrated during her
9 hospitalization that her pulse was 140 to 160 and she
10 had shortness of breath, chest pain, abdominal pain?
11 No.

12 So, there's tachycardia and there's
13 tachycardia.

14 Q. Did you review Heather McCants' EKG that was
15 performed during her Rapid Response Team call?

16 A. Yes.

17 Q. And do you have any recollection of what that
18 EKG showed?

19 A. As an obstetrician reviewing an EKG it
20 appeared to be sinus tachycardia.

21 Q. Do you know if an EKG has any telltale signs
22 that are seen in a patient who has a pulmonary embolism?

23 A. Well, one of the things that I know for sure
24 is that you will see an elevated pulse. And that was
25 enough for me to call, you know. That's even before I

1 saw the EKG, based on the report of Nurse Duckworth, I
2 felt confident I needed someone who specialized in
3 medical management of pulmonary embolism.

4 I'm not a specialist. My scope of practice
5 is obstetrics and gynecology.

6 Q. An elevated pulse is an extremely nonspecific
7 finding in a patient; isn't it, Doctor?

8 A. Not in one who has had acute shortness of
9 breath to the point a rapid response has to be called.

10 Q. Okay. So you would conclude that based upon
11 just a physical finding of a rapid pulse that any patient
12 in the world could have a pulmonary embolism?

13 MR. BLOOM: Form.

14 MS. WIDLANSKY: Form.

15 THE WITNESS: You're mischaracterizing what
16 I'm saying. I told you there is tachycardia and
17 there is tachycardia.

18 There are some patients who have underlying
19 cardiac diseases that have already been worked
20 up. There's patients who have an acute change of
21 status, which is this clinical situation, where
22 they have acute onset of shortness of breath,
23 persistent post rapid response, maternal
24 tachycardia, chest pain.

25 I think it is reasonable for a prudent

1 physician to include pulmonary embolism in a
2 differential diagnosis in such a patient,
3 especially if they know this patient has been on
4 prolonged bedrest; this patient is five foot
5 four, more than 330, probably 350 pounds,
6 somewhere in that range; and continued to have
7 persistence of tachycardia despite basic
8 resuscitative efforts, increasing fluids and
9 oxygen.

10 BY MR. SILVA:

11 Q. Did you write any orders on Heather McCants at
12 any point in time during this hospitalization for DVT
13 prophylaxis?

14 A. Yes, I believe she had sequential compression
15 stockings since the time of her initial admission.

16 Q. And you specifically remember writing that
17 order?

18 A. Well, if I didn't write the order one of the
19 physicians on my team wrote the order, but the order
20 was written, yes.

21 Q. We'll get to that in a little bit. But can a
22 patient who is having an anaphylactic reaction, allergic
23 reaction have an increased pulse?

24 A. Yes.

25 Q. Did you ever have a prior patient/physician

1 relationship with Heather McCants prior to you being
2 assigned as her attending physician at St. Mary's Medical
3 Center?

4 MR. MITTELMARK: Object to the form.

5 THE WITNESS: I don't believe so.

6 BY MR. SILVA:

7 Q. Can you tell me how it came about that you were
8 assigned to be her attending physician on January 12,
9 2011?

10 A. As was my general practice at St. Mary's,
11 I've been part of the perinatal transfer team when
12 outlying physicians and hospitals have patients whose
13 obstetrical medical acuity exceeded their capacity.

14 One of the great things about St. Mary's is
15 it subserves about a ten county area as the most
16 experienced level three nursery. And it's not
17 uncommon for patients that have these medical issues
18 to be asked to be transferred.

19 And in order to be transferred you have to
20 have an accepting physician.

21 I need to take this call, if I may? Can we
22 go off the record?

23 THE VIDEOGRAPHER: Off the record at 4:25.

24 (Break in the proceedings.)

25 THE VIDEOGRAPHER: Back on the video record

1 at 4:25.

2 BY MR. SILVA:

3 Q. All right, so sir, because she was transferred
4 to St. Mary's you were assigned to take care of her as
5 the attending physician?

6 A. No, I wasn't assigned. When I first started
7 in 1987 I started the perinatal transfer team, whose
8 purpose was -- because I was also the first assistant
9 director of the high risk, it's called the HRPIC
10 (phonetic) Program at St. Mary's.

11 So, like I said, one of, you know, my
12 passion is high risk obstetrics. So when I came here
13 I started the high risk perinatal transfer team and
14 started the high risk program for patients.

15 And then I stepped down and a perinatologist
16 runs the program now. But it was not uncommon for
17 high risk patients to be identified in counties that
18 don't have the level of acuity that St. Mary's has.
19 And so they have to transfer them to a physician who
20 is willing to accept transfer.

21 And I'm one of those physicians. And I was
22 contacted, and I agreed to accept transfer.

23 Q. Who were you contacted by?

24 A. I don't recall specifically. It may have
25 been the transfer center. It may have been a

1 physician.

2 Q. It wasn't Heather McCants, was it?

3 A. No.

4 Q. It was somebody from St. Mary's Medical Center?

5 MR. MITTELMARK: Object to the form.

6 THE WITNESS: I don't remember. I don't
7 remember.

8 BY MR. SILVA:

9 Q. Do you know if the patient, Heather McCants,
10 came straight to the OB unit or did she go to the
11 emergency room?

12 A. I believe she was previously already
13 hospitalized at Indian River Medical Center, and she
14 was transferred to actually 2 South.

15 So I don't think -- she may have had a short
16 visit in triage on her way upstairs.

17 Q. Are there other physicians who have privileges
18 at St. Mary's Medical Center who take care of similar
19 types of patients like Heather McCants?

20 A. Yes.

21 Q. Like who? What names?

22 A. I can't say that I know the whole list.

23 Q. Give me some names. Any names.

24 A. Well, among the perinatologists there's
25 Dr. Jones, Dr. Morel, possibly Dr. Guidetti and

1 Dr. Deutsch during that time period.

2 There is Dr. Litt, Dr. -- hold on, it will
3 come to me -- there are several.

4 Q. Do you know how you were picked instead of any
5 one of those doctors to take care of Heather McCants?

6 A. Are you trying to suggest I'm not a good
7 pick?

8 Q. No, I'm not at all. I'm trying to ask you why
9 you were picked as opposed to somebody else.

10 A. Why not me? I told you I started the high
11 risk program in 1987. I was the originator of the
12 perinatal transfer program. I had relationships among
13 many doctors in the ten county area that don't have a
14 level two nursery, that don't have that level of
15 expertise that makes St. Mary's stick out in terms of
16 a perinatal transfer center.

17 Q. Why wasn't Dr. Morel picked by St. Mary's?

18 MR. MITTELMARK: Objection to the form.

19 THE WITNESS: Well, St. Mary's didn't really
20 make the pick. I think the pick initiated with
21 the attending physician at Indian River. And
22 possibly he knew of the availability of my
23 services. I also work in conjunction with a high
24 risk physician, Dr. Stoessel, Dr. Deutsch and
25 Dr. Guidetti.

1 BY MR. SILVA:

2 Q. Do you know if there is any documentation in any
3 medical records at the Indian River Medical Center that
4 pick you as the attending physician at St. Mary's?

5 MR. MITTELMARK: Objection to form.

6 MR. BLOOM: Join.

7 MS. WIDLANSKY: Join.

8 THE WITNESS: Yeah, I don't know the answer
9 to that. I don't recall seeing it, but it may
10 exist, I don't know.

11 BY MR. SILVA:

12 Q. Do you know who Heather McCants' prior OB was?

13 A. I know of him, but I don't know him
14 personally.

15 Q. What's his name?

16 A. Give me one second. Dr. Zoffer, Z-O-F-F-E-R.
17 And in the past, I believe I have accepted patients
18 for transfer from Dr. Zoffer.

19 Q. Did you talk to Dr. Zoffer specifically
20 regarding Heather McCants?

21 A. I don't recall.

22 Q. If you had would you have listed that in the
23 medical records?

24 A. Not necessarily.

25 Q. What is the function of the attending OB at

1 St. Mary's?

2 A. I don't know what you mean by attending OB.

3 Q. Did you consider yourself the attending OB at
4 St. Mary's for Heather McCants?

5 A. I guess that's one way you could describe my
6 role, yes. I was the primary care physician
7 responsible for Ms. McCants.

8 Q. Did you evaluate her on the days prior to
9 January 26, 2011?

10 A. Yes.

11 Q. Did you ever conclude that she had
12 chorioamnionitis?

13 A. No.

14 Q. In fact, she had some intravenous antibiotics
15 the first few days, and then those were discontinued,
16 right?

17 A. Per protocol, yeah, usually you would give
18 them for like Zithromax -- I'm sorry, you give a
19 couple of antibiotics for up to five days and then you
20 discontinue them if there were no signs of acute
21 infection, correct.

22 Q. And they were discontinued in Heather McCants'
23 case, correct?

24 A. Correct.

25 Q. When you first got privileges at St. Mary's

1 Medical Center did you ever have any conversations with
2 anyone from risk management or the hospital regarding any
3 commitment to quality of care initiatives to patients?

4 A. You are asking me to comment on something
5 that may have happened 27 years ago?

6 Q. Yeah, sure.

7 A. I don't recall.

8 Q. Okay. How about any time through your
9 recredentialling process every two years?

10 A. What was the question?

11 Q. Ever have any conversations with anyone at
12 St. Mary's regarding commitment to quality of care to
13 patients?

14 A. I don't have an independent recollection of
15 that.

16 Q. I'm going to have you take a look at this
17 document, which is going to be marked as plaintiff's
18 Exhibit Number 6.

19 Take a look at that, sir.

20 (Plaintiff's Exhibit No. 6 was marked for
21 identification)

22 BY MR. SILVA:

23 Q. Have you ever seen that document before?

24 A. No.

25 (Plaintiff's Exhibit No. 7 was marked for

1 identification)

2 BY MR. SILVA:

3 Q. This is, Exhibit Number 7 is a St. Mary's
4 Commitment to Quality brochure. Have you ever seen that
5 document before today?

6 A. No.

7 (Plaintiff's Exhibit No. 8 was marked for
8 identification)

9 BY MR. SILVA:

10 Q. I'll have you take a look at plaintiff's Exhibit
11 Number 8, Tenet Standards Of Conduct.

12 Prior to today have you ever seen that document?

13 MR. MITTELMARK: Object to the form.

14 THE WITNESS: Yes.

15 BY MR. SILVA:

16 Q. And when was the last time you saw it?

17 A. Maybe a year or two ago.

18 Q. In what setting did you see that document?

19 A. You know, I think I actually went to a
20 meeting where this may have been in the back where the
21 coffee and donuts were. They had like a stack of
22 them.

23 Q. And did you ever take one for your --

24 A. Yeah.

25 Q. Your use?

1 A. Yes.

2 Q. Did you ever read it?

3 A. Yeah.

4 Q. Did you understand that Tenet, the parent
5 company of St. Mary's Medical Center has a specific
6 standard of conduct for physicians and employees that
7 practice at its facilities?

8 MR. MITTELMARK: Object to form.

9 THE WITNESS: Yes.

10 BY MR. SILVA:

11 Q. Okay. Did you understand that that includes the
12 safety of patients, and during the provision of health
13 care?

14 A. Yeah.

15 Q. And do you recall reading in this standard of
16 conduct the requirements for medical records, maintaining
17 medical records and documenting medical records?

18 MR. MITTELMARK: Object to the form.

19 THE WITNESS: I'm sorry, is that in here? I
20 don't recall seeing that in here.

21 If it's in here, you know, I did read through
22 it in terms of like right to privacy and so
23 forth. I also was aware they had an office of
24 inspector general agreement with, I believe the
25 Department of Justice and maybe CMS in regard --

1 it was actually what led to something like this
2 because I remember the news reports, and then I
3 remember that they had to come up with a
4 corrective action plan.

5 It seems like the top four or five health
6 provider systems all found themselves in hot
7 water. And my sister worked for the US Courts so
8 I was familiar with the Department of Justice
9 investigation and the outcome.

10 BY MR. SILVA:

11 Q. Right.

12 A. But this is boilerplate, this is not only for
13 Tenet. HCA has one, they had the same or similar
14 problems.

15 Q. Sure.

16 A. I don't know about UHS before, but they all
17 basically operate under a compliance plan and they
18 have to -- and this is very boilerplate.

19 MR. MITTELMARK: I have to move to strike as
20 nonresponsive to the question and irrelevant, but
21 I appreciate it.

22 BY MR. SILVA:

23 Q. Thank you for your answer. And I also wanted to
24 ask you does this standard of conduct, if you recall,
25 also basically require that all employees, including

1 physicians practicing at Tenet facilities, abide by the
2 standards of care with regard to patients?

3 MR. MITTELMARK: Objection to form.

4 MS. WIDLANSKY: Join.

5 MR. BLOOM: Join.

6 THE WITNESS: Yes.

7 BY MR. SILVA:

8 Q. I want you to turn to page 9 please, left
9 bottom. It is numbered page 9.

10 A. Okay.

11 Q. Does it state -- I'll let you get there.

12 A. Okay, I'm here.

13 Q. There is an area here that says: We are honest
14 in what we write, say, and do.

15 You see that? And it says: Our patients depend
16 on us and their physicians to accurately document their
17 medical records.

18 And it goes on to say that basically the medical
19 records have to be kept in accurate form, and that late
20 entries have to be noted as such, as late entries in
21 accordance with policy. Do you see that second
22 paragraph?

23 A. Yes.

24 MR. MITTELMARK: Object to the form if there
25 was a question.

1 BY MR. SILVA:

2 Q. And you agree that is a policy that should be
3 followed by physicians and nurses at this facility?

4 MR. MITTELMARK: Object to the form.

5 MS. WIDLANSKY: Join.

6 THE WITNESS: Yes.

7 BY MR. SILVA:

8 Q. Did anyone from Tenet or St. Mary's ever
9 approach you and discipline you for failing to document
10 interactions with patients in the medical record --

11 MR. MITTELMARK: Object to the form.

12 THE WITNESS: No.

13 BY MR. SILVA:

14 Q. -- that you've had.

15 A. Well, actually one time I think after a joint
16 commission interview or joint commission survey, one
17 of my charts was pulled and I had used an unapproved
18 or altered abbreviation.

19 And that abbreviation were the letters QD
20 which stands for everyday in Latin. And the joint
21 commission no longer allowed the use of QD. And I did
22 remember getting a letter with a list of a page full
23 of abbreviations that were no longer acceptable.

24 Again, old dogs like me, old ways sometimes
25 change slow. I remember that happened. That may be

1 in my file somewhere. But not in terms of, you know,
2 a dating issue or postdating issue or something like
3 that.

4 Q. Anyone ever approach you from St. Mary's Medical
5 Center or Tenet and discipline you on not following
6 policies and procedures and guidelines?

7 MR. MITTELMARK: Object to the form.

8 THE WITNESS: No.

9 BY MR. SILVA:

10 Q. I think you mentioned earlier you performed a
11 little over a hundred stat C-sections in your career.

12 How many of those do you think have been
13 performed at St. Mary's?

14 A. I don't know, I don't keep statistics.

15 Q. More than ten over your career?

16 A. Possibly.

17 Q. How quickly can a stat C-section be performed at
18 St. Mary's, in your experience?

19 MS. WIDLANSKY: Form.

20 MR. BLOOM: Join.

21 THE WITNESS: In the amount of time it takes
22 a patient to be rolled down from the labor
23 delivery unit to an unoccupied operating room.
24 Whatever that amount of time may be. Fairly
25 quickly.

1 BY MR. SILVA:

2 Q. Five minutes?

3 A. Yes.

4 Q. And in your opinion, at St. Mary's how quickly
5 have you been able to perform an emergent C-section,
6 prior to Heather McCants' case?

7 A. Well, there's a difference if the patient is
8 in triage or on the first floor, which is where the
9 operating room is located.

10 Q. Yes.

11 A. It would occur more quickly than if the
12 patient is on the second floor and have to take an
13 elevator down.

14 Also, if the patient is of normal weight and
15 stature, as opposed to either short and morbidly
16 obese. You know, the prep time is slower when the
17 patients are bigger, as I mentioned before. Sometimes
18 you have to use two prep kits because they only cover
19 a certain amount of skin surface area.

20 So, and sometimes the patients have to have,
21 if they're morbidly obese they have to have a special
22 positioning such that their panniculus can be moved
23 out of the way of where the surgery is going to occur.

24 So many times that involves taping the
25 panniculus up involving a special type of tape and

1 certain type of positioning. And sometimes they move
2 -- different patients move at different rates from the
3 either the wheelchair or bed they were brought into
4 the operating room.

5 And some patients, you know they have to be
6 centered. Some patients require more than one strap
7 because their legs are large. And in order to strap
8 and sustain the patients consistent with safety
9 recommendations, they may require two straps. So
10 somebody has to go get the second strap.

11 So there are a lot of technical factors that
12 go into how fast is fast.

13 Q. And is that stuff that you just described done
14 by nurses?

15 A. Depends. If it is a stat and everyone works
16 together. If it's stat and I know the patient is big,
17 I might go get the second strap. Or I might be -- you
18 may be asked to do something that you might not
19 necessarily do in a stat situation.

20 And in an emergent situation, same thing.
21 Sometimes, you know, you might not hit -- you might
22 not have all the things that you're going to need.
23 For example, in an obese patient it is not unlikely
24 that anesthesia needs to give an extra long Tuohy and
25 regular size spinal needles are immediately available.

1 The extra long needles they keep sequestered in an
2 anesthesia workroom. So sometimes the
3 anesthesiologist has to get his unique supplies to
4 meet the needs of a specific patient.

5 Q. So, if the anesthesiologist has to do that that
6 is going to delay performing the procedure, right?

7 MR. PUYA: Objection to form.

8 THE WITNESS: Yeah. Not always. It's only if
9 needed. They go get everything they think
10 they're going to need based on their interview
11 with a patient.

12 Just like the nurses don't always have the
13 second strap available, but once they're alerted
14 there is a patient that has a particular need.
15 We have patients that are sometimes paralyzed and
16 you don't want them falling off the table. So
17 they may have to be double strapped.

18 So they would require more time than a
19 patient that may be, you know, a normal size
20 patient with a normal size emergent C-section.

21 So even under a category of emergent, under
22 the category of a regularly scheduled C-section,
23 again those same needs exist.

24 If it comes to be that the patient has an
25 unusually thick back tissue and they may need the

1 extra long Tuohy spinal needle, the same delay
2 will happen. The doctor will have to go to
3 wherever they sequester those needles and get
4 one.

5 BY MR. SILVA:

6 Q. Do you know if Heather McCants was paralyzed?

7 A. No, she was not paralyzed.

8 Q. Okay. Do you know if Heather's weight delayed
9 the type of anesthesia that she required in any way?

10 MR. PUYA: Object to the form.

11 THE WITNESS: No, I'm not privy to understand
12 what Dr. Lane's decisions were in that regard.

13 BY MR. SILVA:

14 Q. Okay. Do you know if there is any reason that
15 Heather McCants could not have received general
16 anesthesia on January 26, 2011, from an obstetric's
17 standpoint?

18 MS. WIDLANSKY: Form.

19 THE WITNESS: Yes, and let me tell what you I
20 know. It was after lunch. She was not in PL,
21 she was on a regular diet. So more likely than
22 not she'd had lunch.

23 Lunch is generally served on Turner 2 South
24 about one o'clock. And we are talking about two
25 hours later.

1 So that puts her with her other risk factors.
2 She was five-foot four, I believe. 350 was a
3 good estimate. She had a short neck. And these
4 are issues, obstetrically that I understand
5 because of my knowledge, training, and experience
6 that might not make her an ideal candidate for
7 general endotracheal anesthesia.

8 Now, obviously the biggest factor was this
9 was not a stat C-section, this was an emergent
10 C-section. And the baby had undergone an
11 intrauterine resuscitation on purpose, so it
12 would be as well-off as it could be under the
13 circumstances.

14 And a baby delivered during a bradycardia
15 will probably recover faster inside the uterus
16 with the oxygen and hydration than they do
17 outside. That's why we do an intrauterine
18 resuscitation.

19 Beyond that, for an obstetrician looking at
20 anesthesia we would not want someone like
21 Ms. McCants, who might already have some medical
22 compromise, to undergo, for example, aspiration.
23 Okay. We don't want to make the matters any
24 worse than what we have.

25 So we are all on board with having her have

1 whatever the safest form of anesthesia that's
2 appropriate.

3 Now, the flip to that is I certainly don't
4 want her to have, you know, anesthesia that's
5 going to take an excessive amount of time to
6 administer. Dr. Lane, because he was the primary
7 obstetrical anesthesiologist was exceptionally
8 deft and capable at administering spinal
9 anesthetics. He would do four or five or six a
10 day some days. Okay. And five days, 30 a week,
11 120 a month or more.

12 The man could do a spinal faster than most
13 doctors could do general endotracheal. So I
14 didn't see him, you know, whatever his
15 professional opinion of what's the safest form of
16 anesthesia to be a time limiting step in the care
17 of Ms. McCants.

18 BY MR. SILVA:

19 Q. Did you tell Dr. Lane not to perform general
20 anesthesia?

21 A. I would never tell an anesthesiologist what
22 type of anesthesia to perform. I can only present to
23 them what the clinical situation is and the urgency
24 for delivery.

25 Q. Do you know what a subarachnoid block is?

1 A. The name is familiar, but I couldn't
2 technically explain it to you, no.

3 Q. Do you know what the difference between a
4 subarachnoid block and an epidural is?

5 A. No.

6 Q. Do you know how long it took Dr. Lane to achieve
7 anesthesia so you could perform the C-section by a
8 subarachnoid block on January 26, 2011, on Heather
9 McCants?

10 A. No.

11 Q. When you came into the operating room, did it
12 appear that general anesthesia had been administered?

13 A. No.

14 MR. PUYA: Object to form.

15 BY MR. SILVA:

16 Q. Was Heather McCants awake?

17 A. Yes.

18 Q. Was she alert during the procedure?

19 A. I can't tell because, you know, they kind of
20 quickly put a drape over there as a barrier between
21 their chest and the operating area.

22 Q. In the best of circumstances how quickly can you
23 perform an emergent C-section at St. Mary's?

24 MS. WIDLANSKY: Form.

25 BY MR. SILVA:

1 Q. You can answer.

2 A. Depends on many things. If the patient is on
3 Turner 1 North, which is the usual labor area and it
4 is an unoccupied operating room, an emergent Caesarian
5 section could be performed, could be initiated, you
6 know, incision within ten minutes.

7 Q. And do you know if St. Mary's performs practice
8 runs for stat C-sections?

9 A. Do I know with certainty? I've seen a drill
10 run before.

11 I mean, do they run -- do they do like a
12 practice drill?

13 Q. Yes, like practice runs.

14 A. Yeah, I've seen them do practice runs for
15 three or four different types of things: Postpartum
16 hemorrhage, precipitous delivery, a code, C-section.

17 I don't know how often they do it, but I've
18 unfortunately been there when they were doing a drill.

19 Q. Have you ever participated in a C-section drill?

20 A. No, not at St. Mary's.

21 Q. Okay, never at St. Mary's.

22 Do you know why they do the C-section drills?

23 A. I would imagine part of -- as you know in
24 2004 JCAHO suggested in their credentialing of
25 hospitals that periodic drills should be performed in

1 high risk areas, such as the labor and delivery unit
2 for those commonly, you know commonly encounter
3 emergencies.

4 And I would imagine they feel as busy as a
5 place doing 3 or 400 deliveries a month, that they
6 still need to drill even though we run into needs for
7 stat C-sections, postpartum hemorrhages with some
8 regularity.

9 Q. You are using the term JCAHO, the jury might not
10 be familiar with? Can you define that?

11 A. Yes, the Joint Commission of Hospital
12 Accreditation is an independent organization that sets
13 a higher standard than actually necessary for a
14 hospital to exist as an entity, but it's one that many
15 licensing organizations like to see that a hospital
16 is accredited because that means they -- an
17 independent organization has come in and evaluated a
18 hospital in top to bottom in a very large number of
19 categories.

20 Their inspection teams are usually physicians
21 who have extensive knowledge in both the regulation
22 and the general practice of medicine. And they very
23 thoroughly check out to see whether the hospital is in
24 compliance with the rules.

25 Now, each hospital is given something like

1 seven strikes. When the inspection is over they get a
2 report card and they tell them where the hospital did
3 good and where the hospital did not good.

4 And if they hit a certain number of strikes,
5 which I believe the magic number is seven they will
6 not be accredited unless some corrective plans is
7 approved and agreed and a reinspection indicates
8 passage.

9 MR. MITTELMARK: Move to strike as
10 nonresponsive.

11 BY MR. SILVA:

12 Q. And if hospital is not accredited, does that
13 allow them to even take care of Medicare patients?

14 MR. MITTELMARK: Object to the form.

15 THE WITNESS: Yes. Again, I'm not a
16 regulatory expert. I know that some insurances,
17 including Medicare, may have that as part of
18 their requirement. But there may also be other
19 explanatory reasons why you could continue to
20 participate in the program and yet be in a
21 transitional phase with JCAHO.

22 BY MR. SILVA:

23 Q. For a stat C-section do you think time is of the
24 essence?

25 A. For a stat, yes.

1 Q. How about for an emergent C-section?

2 A. Well, emergent is designed as a C-section
3 that occurs as quickly as possible when an operating
4 room, anesthesia, and obstetrical surgical team is
5 available to perform the procedure.

6 So within that time constraint, yes. It's
7 not like, okay, we'll do it on next Thursday at
8 four o'clock like a regularly scheduled C-section or
9 what is called a scheduled C-section.

10 Time is a component, but not to the exclusion
11 of breaking all the rules. Not to the exclusion of
12 safety measures. Not to the exclusion of taking the
13 patient's independent risk factors into consideration,
14 both the mother and the child.

15 Q. So, according to your definition for stat
16 C-section versus an emergent C-section, the difference is
17 in a stat C-section its got to be done as quickly as
18 possible, regardless of whether there is an available OB
19 and operating room team ready for the procedure, right?

20 MR. MITTELMARK: Object to the form.

21 MS. WIDLANSKY: Join.

22 THE WITNESS: That might not be an exact
23 characterization.

24 Let's see what this thing says here. What is
25 a stat C-section. Stat C-section to me based on

1 this is emergencies within perinatal unit says
2 they have a lot of contingencies so this thing
3 goes off no matter what.

4 If they can't find the OB anesthesia guy you
5 call the designated pager number, you call the
6 main O.R. and get the backup guy up there.

7 You know, this seems to have a catch all
8 provision of what is a stat. Which is very
9 different than as soon as possible.

10 BY MR. SILVA:

11 Q. Right. And so on the date of Heather McCants'
12 C-section on January 26, 2011, because you classified it
13 as an emergent C-section, you felt it was okay to wait
14 for the other procedure to finish before you started her
15 procedure, correct?

16 A. Correct. And during that time her baby's
17 heart rate stayed well.

18 Q. But yet you can't tell us what the baby's oxygen
19 saturation was in the uterine, correct?

20 MS. WIDLANSKY: Form.

21 THE WITNESS: No. The technology to do that
22 simply doesn't exist.

23 BY MR. SILVA:

24 Q. Right, it's impossible.

25 A. It's impossible. Well, it's possible, but

1 the mechanisms of the technology carry their own risk.

2 Q. Does the standard of care require once the stat
3 C-section is called by an OB for the nurses, the OB
4 nurses to notify the operating room and the anesthesia
5 department for that?

6 A. If we are to look at this policy and
7 procedure, yes.

8 Q. Did you know at any point in time before you
9 arrived at the hospital that Lisa Sanches had evaluated
10 Heather McCants on January 26, 2011?

11 A. I have no recollection of knowing that, no.

12 Q. Did Janice Duckworth ever tell you that?

13 A. I don't have an independent recollection of
14 that.

15 Q. You didn't document anywhere in your note that
16 you wrote, which is --

17 A. The on-call note?

18 Q. Yes, the on-call note.

19 A. I'll show it to you.

20 Q. Well, I marked it as an exhibit. Let's see if
21 we can find it.

22 A. It looks like that. I'll give you that one
23 back too.

24 I do not have it. Here it is.

25 Q. Did you document on your on-call note --

1 A. No, I did not.

2 Q. -- that Dr. Sanches responded to the Rapid
3 Response Team?

4 MR. BLOOM: Form.

5 THE WITNESS: No, I did not.

6 BY MR. SILVA:

7 Q. When you arrived at the hospital after you poked
8 your head into the hospital operating room that Dr. Lane
9 was in, did you have anymore conversations with Dr. Lane
10 prior to Heather McCants' procedure?

11 A. It's possible, but I don't have independent
12 recollection as to the content.

13 Q. Did you observe Dr. Lane perform the
14 subarachnoid block on Heather McCants?

15 A. No.

16 Q. Did you ever talk to Dr. Sanches at any point in
17 time prior to the C-section?

18 MR. BLOOM: Form.

19 THE WITNESS: No.

20 BY MR. SILVA:

21 Q. Do you know if Dr. Sanches was available to
22 perform an emergent C-section prior to you arriving at
23 the hospital?

24 MR. BLOOM: Form.

25 THE WITNESS: No, I don't know.

1 BY MR. SILVA:

2 Q. Do you know if any of the nurses asked
3 Dr. Sanches to perform a C-section on Heather McCants to
4 Dr. Sanches?

5 A. I don't know.

6 Q. Did anyone tell you that Dr. Sanches instructed
7 the nurses not to perform a stat C-section?

8 MR. BLOOM: Form.

9 THE WITNESS: I don't know that either.

10 BY MR. SILVA:

11 Q. Did you see Dr. Sanches anywhere in the
12 operating room prior to Ms. McCants' procedure?

13 A. No.

14 Q. Did you tell the nurses what your estimated time
15 of arrival was when you spoke with Janice Duckworth?

16 A. I don't recall that.

17 Q. Were you -- were there any other people around
18 you when you got that pager call at Good Sam?

19 A. No, I was past the nurses' station in a
20 hallway where patient's rooms doors were closed.

21 Q. Do you know who Patrick Hare is?

22 A. No.

23 Q. Have you ever worked with him in any capacity?

24 A. I don't know who he his.

25 MR. MITTELMARK: Object to form.

1 BY MR. SILVA:

2 Q. Okay. Do you know if anyone identifying himself
3 as Patrick Hare called you to notify you that Heather had
4 suffered a respiratory arrest with fetal heart rate going
5 into the fifties?

6 MR. MITTELMARK: Object to the form.

7 THE WITNESS: No.

8 THE VIDEOGRAPHER: I need to change the tape
9 again. Off the video record at 4:59.

10 (Break in the proceedings)

11 THE VIDEOGRAPHER: Back on the record at
12 5:10, beginning of tape three.

13 BY MR. SILVA:

14 Q. Okay. We are back on the record.

15 Sir, do you know if Heather McCants had an
16 epidural in place prior to you calling the C-section?

17 A. Yes, I know that she did not.

18 Q. Earlier we were talking about your discharge
19 summary, which is plaintiff's Exhibit Number 2.

20 Did you dictate this yourself?

21 A. Yes.

22 Q. And at some point in time after the delivery a
23 CT angiogram was done that showed no evidence of acute
24 pulmonary embolism; is that right?

25 A. Yes.

1 Q. So, in fact, she did not have a pulmonary
2 embolism, correct?

3 A. Correct.

4 Q. When you say here: Prolonged fetal
5 deceleration, why did you use that terminology as opposed
6 to ten minutes of fetal bradycardia?

7 MR. MITTELMARK: Object to form.

8 THE WITNESS: Because the deceleration was
9 not a ten minute deceleration. At some point it
10 crossed over a hundred and 10 beats a minute, at
11 which it was no longer a deceleration. And that
12 occurred before nine minutes, but because of the
13 quality of the tracing I couldn't tell you
14 exactly.

15 I mean the deceleration was certainly more
16 than five minutes, but I can't say for sure that
17 it was the entire nine to ten minutes.

18 BY MR. SILVA:

19 Q. Then you state here: Persistent fetal
20 bradycardia. What do you mean by that?

21 A. Exactly what I just said. That the heart
22 rate was low for a period of time that's documented,
23 then it rises. But I can't tell you -- the tracing is
24 not of a sufficient quality that I can tell you it
25 stops exactly right here, and it's okay from this

1 point forward.

2 Q. And then you state: Persistent fetal
3 tachycardia. What did you mean by that?

4 A. That was also an error, that was persistent
5 maternal tachycardia.

6 Q. That was an error also?

7 A. Yeah, that's why I didn't sign it.

8 Q. Okay. And again, did you ever go back and make
9 any changes to correct this medical record?

10 A. No. And this document didn't harm
11 Ms. McCants in any way.

12 Q. Well, you understand that it's important to keep
13 accurate medical records, for example for this scenario
14 now that a medical malpractice case has brought against
15 you, are you aware it is important to keep accurate
16 medical records?

17 A. Sure, but if you look at the documentation,
18 for example, if Dr. Jumapao's note, she also indicates
19 she had an emergent C-section. And she captured that
20 when she did her initial consultation immediately
21 after the C-section, and she certainly had no dog in
22 the fight.

23 Q. Did you see other parts of the medical record
24 where its referred to as a stat C-section?

25 A. Well, Dr. Stoessel wrote something -- let me

1 see what he wrote the next day when he rounded on her.
2 He certainly didn't put down a stat on the note from
3 ICU he wrote down "emergency C-section" on
4 January the 26th for the ICU.

5 Q. Emergency C-section, right?

6 A. Yeah.

7 Q. Was that an error also?

8 A. I don't know. I believe that may be
9 Dr. Deutsch, may not be Dr. Stoessel.

10 Q. What kind of doctor is Dr. Deutsch?

11 A. High risk doctor, a maternal fetal
12 specialist.

13 Q. Like yourself?

14 A. No, no, I'm not a maternal fetal specialist.
15 I'm a regular OBGYN who is beyond a hobbyist in high
16 risk, but I didn't do the additional training and
17 testing to become a maternal fetal specialist.

18 Q. Does Dr. Deutsch have more training than you do
19 then?

20 A. Yes.

21 Q. Okay. What training is required to be a
22 maternal fetal specialist?

23 A. I think it's three extra years of post, you
24 know, four years OBGYN residency. So an additional
25 three years and you have to be boarded in OB -- in

1 OBGYN and you have to be boarded in maternal fetal.

2 Q. And he refers in his note to an emergency
3 C-section, right?

4 A. Right. But his note was 7:00 p.m.
5 Dr. Jumapao, the hospitalist, indicated it was an
6 emergent, which is as accurate as it can be.

7 Q. Does Dr. Jumapao have any OB training?

8 A. I don't know what training Dr. Jumapao has.

9 Q. Is Dr. Jumapao an intensive -- I think you said
10 earlier in your deposition --

11 A. Yes, correct.

12 Q. Do you know if Dr. Jumapao is an obstetrician?

13 A. I know she's not.

14 Q. And you know also she's not a maternal fetal
15 specialist, right?

16 A. Correct.

17 Q. And again, Dr. Deutsch, a maternal fetal
18 specialist wrote down this is an emergency C-section,
19 right?

20 A. Right. And as I mentioned before this is the
21 problem with the Chinese telephone problem that people
22 are hearing what they want to hear and writing what
23 they want to write, whether it accurately reflected
24 what it was.

25 Since I was there and I was the one who

1 performed the Cesarean section and I'm telling you
2 it's emergent. It's emergent.

3 Q. Did you ever go back and confront Dr. Deutsch
4 and tell him this is not an emergency C-section, this is
5 an emergent C-section?

6 A. You know, whether he writes emergent, stat,
7 or whatever, didn't hurt Ms. McCants.

8 And as I said, sometimes people are
9 describing things that are -- that they don't really
10 have enough factual information on to make the most
11 accurate, precise thing.

12 Sometimes it's consequential, I think it is
13 of no consequence. I understand you're trying to
14 create a dust-up about it, but frankly it makes no
15 difference.

16 Q. That's according to your opinion, right?

17 A. Absolutely.

18 Q. You understand that we are here today for a baby
19 who has cerebral palsy and can't walk or talk or do
20 anything for himself?

21 A. Correct. The mother came in with ruptured
22 membranes, premature, with a number of maternal risk
23 factors, all of which could explain all of that,
24 correct.

25 Q. Yes, it could, and it also could not explain it,

1 which means that isn't it possible that Heather McCants
2 baby has cerebral palsy today due to lack of oxygen
3 during the birthing process?

4 MR. PUYA: Form.

5 MS. WIDLANSKY: Form.

6 MR. BLOOM: Form.

7 MR. MITTELMARK: Object to the form, also
8 argumentative.

9 BY MR. SILVA:

10 Q. You think it's not possible?

11 MS. WIDLANSKY: Form.

12 THE WITNESS: No.

13 BY MR. SILVA:

14 Q. According to your testimony you are telling us
15 that the reason that Heather McCants' baby today can't
16 walk, talk, or communicate, or take care of himself has
17 nothing to do with any issues of hypoxia during the
18 birthing process, correct?

19 MS. WIDLANSKY: Form.

20 THE WITNESS: I don't see the phrase
21 "hypoxic" written in my notes. I recognize that
22 also Ms. McCants had a positive alpha fetal
23 protein, which is a predictor of the negative
24 potential neonatal outcome, no matter what
25 transpires after that AFP, that abnormal AFP.

1 So, there are many factors, prematurity,
2 things that happened after the delivery that
3 could explain what happened to this baby.

4 BY MR. SILVA:

5 Q. Have you ever delivered a baby in your career
6 that was premature and ended up completely healthy, as
7 far as in the absence of cerebral palsy?

8 MS. WIDLANSKY: Form.

9 THE WITNESS: Depends on how early, so yes.

10 BY MR. SILVA:

11 Q. Okay. And so it's possible that babies can be
12 born prematurely and go on to lead a completely healthy,
13 normal life, isn't it?

14 MR. MITTELMARK: Objection to form.

15 MR. BLOOM: Join.

16 THE WITNESS: It's in the realm of
17 possibility, yes.

18 BY MR. SILVA:

19 Q. I think there are going to be plenty of jurors
20 that know someone who's had a premature baby that has
21 nothing wrong with it; would that be out of the ordinary?

22 MR. BLOOM: Objection to form.

23 MS. WIDLANSKY: Objection to form.

24 BY MR. SILVA:

25 Q. You can answer.

1 A. Your hypothetical depends on the specifics of
2 the individual case.

3 Q. And in this case, of course, you're a defendant,
4 Dr. Sanches is a defendant, St. Mary's Medical Center is
5 a defendant, and Dr. Lane, the anesthesiologist is a
6 defendant; were you aware of that before today?

7 A. Yes.

8 Q. I'll turn your attention now to plaintiff's
9 number 9. Do you know a Dr. Marie Ambroise?

10 A. The last name Ambroise is familiar. She may
11 be a neonatologist.

12 Q. Do you recall seeing her in the room that day?

13 MR. BLOOM: Form.

14 THE WITNESS: Not specifically, no.

15 (Plaintiff's Exhibit No. 9 was marked for
16 identification)

17 BY MR. SILVA:

18 Q. Do you know what she looks like?

19 A. Well, when we are in the operating room you
20 only see their eyes.

21 Q. Well, in all the years that you've worked at
22 St. Mary's Medical Center have you ever had the occasion
23 to speak to Marie Ambroise, the neonatologist?

24 A. Yes.

25 Q. Tell me what she looks like.

1 A. I can't recall.

2 Q. Is she a male or female?

3 A. Female.

4 Q. White or black?

5 A. I don't recall.

6 Q. Did you have any conversations with her on the
7 date of the incident?

8 A. No, not that I can recall, other than perhaps
9 asking what were the APGARs.

10 Q. Did you ever review any of her admission notes?

11 A. No.

12 Q. Here is plaintiff's Exhibit number 9, which is
13 the admission note to the neonatal intensive care unit
14 written by Dr. Ambroise. You never reviewed that before
15 today?

16 A. I may have looked at it at some point, but
17 its been quite some time.

18 Q. According to this document the birth weight was
19 1100 grams.

20 A. Correct.

21 Q. Any reason to dispute that?

22 A. No.

23 Q. She has a pregnancy comment in here, two-thirds
24 of the way down on that page. First page.

25 A. Yes.

1 Q. Two-thirds of the way down, pregnancy comment.
2 And can you read that into the record?

3 A. "1/26/11 mother received alteplase for
4 clotted PICC line and went into respiratory distress
5 shortly after that. She was rushed to stat C-section
6 after deceleration noted on tocometer."

7 Q. Is she wrong also? Stat C-section --

8 MR. MITTELMARK: Objection to form.

9 MR. BLOOM: Join.

10 MS. WIDLANSKY: Join.

11 THE WITNESS: Is she wrong? If you're talking
12 about a --

13 BY MR. SILVA:

14 Q. By documenting --

15 A. -- strict obstetrical definition, yes, it's
16 incorrect to say it was a stat. It wasn't a stat by
17 my definition.

18 I do not believe it was a stat by any other
19 primary treater's decisions.

20 Q. Okay. Can you -- the next question is can you
21 tell me how Marie Ambroise, where she got the information
22 that she wrote she was rushed to a stat C-section after
23 decel noted on tocometer. Do you know where she got that
24 information?

25 MS. WIDLANSKY: Form, asking for speculation.

1 MR. MITTELMARK: Object to the form.

2 THE WITNESS: I don't know.

3 BY MR. SILVA:

4 Q. Did you ever have any conversations with
5 Dr. Ambroise where you told her that this was not a stat
6 C-section, that she should correct her medical record?

7 A. No.

8 Q. Is the first APGAR score taken at one minute
9 after birth?

10 A. Yes.

11 Q. So there is no APGAR score taken at -- right
12 directly at the time of birth, correct?

13 A. Correct.

14 Q. Do you know if this baby received oxygen
15 immediately after the birth?

16 A. I believe the summary indicates that it did
17 receive supplemental oxygen.

18 Q. I mean, is that your understanding that any time
19 a child is born in an emergency or emergent C-section,
20 according to your definition, that they receive oxygen
21 immediately after birth?

22 MR. MITTELMARK: Object to the form.

23 THE WITNESS: I would have to -- since I'm
24 not the administrator of oxygen you would have to
25 take that up with either the respiratory

1 therapist or the other members of the delivery
2 team that dealt with the baby as to what the
3 routine is.

4 BY MR. SILVA:

5 Q. Do you know if a baby who receives oxygen
6 immediately after the birth, if that affects their APGAR
7 scores at one minutes and five minutes?

8 MR. MITTELMARK: Object to form.

9 MR. BLOOM: Join.

10 THE WITNESS: It depends on the status of the
11 baby. This baby has an APGAR score of eight at
12 one minute and had an APGAR score of eight at
13 five minutes.

14 Now, it was well-known that this baby was not
15 40 weeks like a regular baby, it was 27 weeks,
16 6 days. I don't even think that's -- yes,
17 27 weeks 6 days is what they indicated.

18 This baby wasn't 7 pounds 8 ounces like a
19 normal baby, normal average baby. This baby
20 weighed 1100 grams, that's a little bit over two
21 pounds.

22 So it comes as no surprise that you know, it
23 certainly wouldn't hurt to give supplemental
24 oxygen, but you are talking about apples and
25 oranges.

1 BY MR. SILVA:

2 Q. Do you know if this baby was intubated?

3 A. It was not intubated as of the procedures at
4 delivery. It wasn't intubated at delivery. If it was
5 asphyxiated it would have been intubated at delivery.

6 Q. Are you sure this baby was not intubated at
7 delivery?

8 A. Well, from plaintiff's Exhibit 9, it says:
9 Supplemental oxygen. Procedures -- yes, it was
10 intubated ultimately. But procedures and medications
11 at delivery.

12 Q. Okay. There is a blood gas performed at 16:50.

13 A. I don't see that. What page is that on?

14 Q. It's on the next to last page. You see that
15 top?

16 A. Okay, yeah, I see it 16:50, I do see it.

17 Q. That would be in laymen's terms 4:50?

18 A. Yes.

19 Q. So, approximately almost an hour after the
20 birth?

21 A. Correct.

22 Q. There is a pH there of 7.22; do you consider
23 that a normal pH?

24 A. Yes.

25 Q. You ever heard of a pH range of 7.35 to 7.45 is

1 a normal range?

2 A. Correct.

3 MR. MITTELMARK: Object to the form.

4 BY MR. SILVA:

5 Q. So, isn't this below the normal range, 7.22?

6 A. Again, what is normal depends on what we are
7 talking about. We are talking about a baby who's
8 27 weeks. Who's admitting diagnosis is prematurity,
9 as I see it here on this other page: Baby admitted
10 for respiratory distress and premature.

11 We are not talking about a 7.8-ounce baby
12 born at seven weeks. You are talking about a baby
13 that was born 12 to 13 weeks premature.

14 We are talking about an 1100-gram baby.

15 Q. Right, right.

16 A. And this baby started grunting in the
17 delivery room and had to get oxygen. Yeah, 7.22 looks
18 pretty good under those circumstances.

19 Q. So, isn't that precisely what we were talking
20 about that a premature baby is even more sensitive to
21 lack of oxygen?

22 MS. WIDLANSKY: Form.

23 THE WITNESS: There is no evidence there is
24 lack of oxygen here, but yeah, they're very
25 vulnerable to lack of oxygen, but they're even

1 more vulnerable to respiratory distress and
2 prematurity in terms of how they will ultimately
3 turn out.

4 BY MR. SILVA:

5 Q. And that's right they would need to receive
6 oxygen immediately after they're born, correct?

7 A. If it's indicated I would imagine the doctors
8 that deal with that issue would do so, yes.

9 Q. And doesn't oxygen immediately after birth
10 affect the APGAR scores?

11 A. It depends on when it's administered. If you
12 are saying it will alter the APGAR score, it depends
13 on when after -- if it's administered within one
14 minute. If it's not administered at one minute then
15 it wouldn't affect the one minute APGAR.

16 Q. Correct.

17 A. If it's not administered at five minutes, why
18 would it affect the five minute APGAR?

19 Q. Well, what if it's administered immediately
20 after birth? That's my question.

21 A. Well, what does immediately means?

22 Q. It means one second, okay? I want you to assume
23 one second after birth, would that affect the one minute
24 APGAR?

25 A. Yes. Has the potential affecting it, but

1 depending on how it's administered.

2 Now, if it's administered by blow by, and the
3 baby has RDS, Respiratory Distress Syndrome, which is
4 what they describe, in fact, they gave her, I believe,
5 treatment for that, it will affect it to a point.

6 But as I see here they gave it nasal CPAP,
7 which is positive pressure ventilation through two
8 nasal cannulas.

9 Q. That means you are pushing the oxygen into the
10 baby by force, right?

11 A. Yeah.

12 Q. Okay.

13 A. And the reason you do that is because the
14 baby needs it.

15 Q. Of course.

16 A. Because it's extremely premature.

17 Q. And isn't that going to affect the one minute
18 and five minute APGAR score, that's my question?

19 MS. WIDLANSKY: Form.

20 THE WITNESS: Only if the nasal cannula is
21 administered before the APGAR score is
22 calculated. It will have no effect if it's
23 administered after the one minute or the
24 five minute APGAR score.

25 BY MR. SILVA:

1 Q. We agree on that. And we agree that if it's
2 administered before the one minute APGAR it's going to
3 affect the one minute APGAR, correct?

4 MS. WIDLANSKY: Form.

5 THE WITNESS: If it's administered before,
6 yes.

7 (Plaintiff's Exhibit No. 10 was marked for
8 identification)

9 BY MR. SILVA:

10 Q. I want you to look at plaintiff's Exhibit number
11 10.

12 This is the actual laboratory report for the
13 blood gas that was performed at approximately 4:54 on
14 1/26/2011 for the baby. And what is the pH according to
15 this document?

16 A. 7.215.

17 Q. Does it have "L" next to it?

18 A. Yes.

19 Q. What does that "L" stand for?

20 A. Low.

21 Q. There is also a base excess there, BE
22 calculated; you see that?

23 A. Yes.

24 Q. What's the level there?

25 A. It says minus 5.1.

1 Q. Okay. So the base excess for this child
2 approximately one hour after its birth was minus 5.1,
3 correct?

4 A. Yes.

5 Q. And the comment below that it says: SP02,
6 94 percent; do you see that?

7 A. Yes.

8 Q. Does that mean that the baby is getting
9 94 percent oxygen?

10 A. Yes.

11 Q. And what is the amount of oxygen in room air,
12 like you and I are breathing?

13 A. About 21 percent, I think.

14 Q. That's right. So this is almost a hundred
15 percent oxygen?

16 A. Closer to a hundred percent than 21, right.

17 Q. Right, it's 94 percent.

18 A. Right.

19 Q. Do you know what the baby's pH was at birth?

20 A. No.

21 Q. Did you order a cord blood gas on this baby?

22 A. No, I did not.

23 Q. Do you know what the baby's base excess was at
24 birth?

25 A. No.

1 Q. Do you know what the protocol is at St. Mary's
2 Medical Center for ordering cord blood gases?

3 A. In general, yes.

4 Q. Tell me.

5 A. It is a policy and procedure -- I'd have to
6 look it up, I don't have it memorized.

7 Q. Okay, that's what I was asking you, do you know
8 what the policy and procedure is just off the top of your
9 head?

10 A. No.

11 Q. Do you know if one exists?

12 A. Not as of 2011, no.

13 Q. What happened in 2011?

14 A. Well, from time to time they come in and out.
15 In other words, there may be times where they have,
16 like for example, for placentas. They have guidelines
17 when they want placentas sent, and they may change.
18 And then one day they decide, because you know, these
19 policies and procedures are malleable, should we say.
20 Sometimes they get banished to the waste
21 basket and other times they get defined to very strict
22 criteria depending on current medical thought.

23 MR. MITTELMARK: Move to strike as
24 nonresponsive.

25 BY MR. SILVA:

1 Q. Do you know if the policy and procedure for
2 performing blood gasses on infants at birth was still in
3 effect at the time that this baby was born?

4 A. No, because when I hand off the baby the baby
5 is no longer my patient, it's the patient of the
6 neonatologist.

7 Q. Is it the discretion of the obstetrician to
8 order a cord blood gas?

9 A. Yes.

10 Q. So you could have ordered one, if you wanted to?

11 A. Correct.

12 Q. Can the obstetrician -- strike that.

13 Can the neonatologist also order a cord blood
14 gas?

15 A. I imagine so.

16 Q. So, neither you nor Dr. Ambroise ordered a cord
17 blood gas, correct?

18 A. Correct.

19 Q. Was there any discussion of transporting Heather
20 McCants for a spiral CT prior to her C-section?

21 A. No.

22 Q. Was there any discussion of transporting Heather
23 McCants to the radiology department for a VQ scan prior
24 to her C-section?

25 A. No.

1 Q. Do you know who called the Rapid Response Team?

2 A. No.

3 Q. Do you know why they called it?

4 A. No.

5 Q. If a nurse on the OB unit is concerned about the
6 fetal wellbeing, can she call an OB at St. Mary's?

7 A. Yes.

8 Q. Is it the standard of care at St. Mary's and any
9 hospital for nurses to follow doctor's orders?

10 A. Yes.

11 Q. Would it have been within the standard of care
12 for the nurses, after you told them that you wanted to
13 perform a C-section, to call the operating room and alert
14 them that the C-section needed to be performed, including
15 anesthesia?

16 MR. MITTELMARK: Object to the form.

17 MS. WIDLANSKY: Form.

18 MR. BLOOM: Join.

19 THE WITNESS: That's one possibility, yes.

20 BY MR. SILVA:

21 Q. If Dr. Sanches had volunteered to perform a
22 C-section, do you think that she could have performed it
23 any quicker than you did?

24 MS. WIDLANSKY: Form.

25 MR. BLOOM: Form.

1 THE WITNESS: In light of what I found when I
2 arrived at the hospital and the operating room is
3 occupied, not very likely. Not significantly
4 sooner, no.

5 BY MR. SILVA:

6 Q. And the reason would be because there was
7 another procedure going on in the other operating room?

8 A. Correct.

9 Q. Do you know if Dr. Lane -- strike that.

10 Do you know how long Heather McCants was in the
11 preoperative, if you will, holding area before she was
12 taken into the operating room?

13 A. No.

14 Q. Do you know what was done to Heather McCants in
15 the operating room prior to you performing her C-section?

16 A. Some of the things from the medical record.

17 Q. Okay. My question is: When Heather McCants
18 arrived in the preop holding area, did you stay in her
19 presence the entire time until you performed the
20 C-section?

21 A. No.

22 Q. Where did you go or what happened in that
23 interval?

24 A. She moved into the room and I went to the
25 wash basin.

1 Q. When you went to the wash basin, that's you
2 clean yourself up for -- scrubbing for surgery?

3 A. Correct, yes.

4 Q. How long does that process normally take?

5 A. A minute or two.

6 Q. And then you went into the room.

7 How long did you have to wait before you could
8 make the incision after you stepped into the room?

9 A. I don't recall.

10 Q. Did you have to wait on any staff to setup for
11 the C-section once you were in the room and ready to
12 perform this procedure?

13 A. No.

14 Q. Did you ever tell any of the nurses on the
15 initial call that you wanted an OB inhouse to evaluate
16 Heather McCants in your absence?

17 A. No.

18 Q. Up until the time that you first laid eyes on
19 Heather McCants was it your understanding that she had
20 not been evaluated by any obstetrician?

21 A. I don't think that I assumed anything.

22 Q. Did you assume one way or the other if she had
23 been seen by another OB?

24 A. No, I didn't assume one way or the other.

25 Q. Did you know if any other obstetrician had

1 evaluated Heather McCants prior to your arrival at
2 St. Mary's?

3 A. No, did not.

4 MR. SILVA: I'm going to mark the delivery
5 summary as plaintiff's Exhibit number 11.

6 (Plaintiff's Exhibit No. 11 was marked for
7 identification)

8 BY MR. SILVA:

9 Q. Here you go, sir. This is the delivery summary
10 for labor and delivery and the delivery date and time is
11 1/26 at 3:52 in the afternoon; do you have any reason to
12 dispute that?

13 A. Correct.

14 Q. It's got delivery location: OR. Then it has
15 underneath that: Shoulder dystocia. What is that
16 referring to?

17 A. I'm sorry, where is it located?

18 Q. Below delivery location O.R., middle of the page
19 it has shoulder dystocia there. What is that?

20 A. I see it, I don't know what that means.
21 There was no shoulder dystocia in this case.

22 Q. Did you ever encounter any shoulder dystocia?

23 A. No.

24 Q. Can an obstetrician encounter a shoulder
25 dystocia during a C-section?

1 A. Yes, I've seen it.

2 Q. The placenta delivery was at 3:53.

3 A. That's what it says.

4 Q. Did you have any trouble delivering the
5 placenta?

6 A. No.

7 Q. Did you perform the APGARs yourself?

8 A. No.

9 Q. Did you see anyone perform the APGARs?

10 A. I did not visually see who performed the
11 APGARs, no.

12 Q. And on the second page there is an area there
13 for cord gasses and it states: No. Correct?

14 A. Correct.

15 Q. Why didn't you order cord gasses in this case?

16 A. Because I did not think it was going to
17 advance the care or treatment of either patient.

18 Q. You weren't concerned about the baby's wellbeing
19 at birth?

20 MS. WIDLANSKY: Form.

21 MR. BLOOM: Join.

22 THE WITNESS: I think it is a
23 mischaracterization of what I said. The baby had
24 an APGAR of 8. The body was pink. The
25 extremities were slightly blue.

1 It had a cry. It had a good, strong cry
2 actually. This kid looked like a champion for
3 2 pounds 6-ounces, champion.

4 Considering it had a prolonged rupture of the
5 membranes, it was in Dr. Ambroise's capable
6 hands. I did not think or did I -- there were no
7 indications or thoughts that this kid
8 demonstrated any sign of hypoxia on the basis of
9 the examination of the baby when I delivered it.

10 And, as I said, if Dr. Ambroise felt she
11 needed a blood gas, she could get a blood gas
12 from the baby, which is even more accurate than a
13 cord blood gas.

14 BY MR. SILVA:

15 Q. And that is according to your recollection,
16 right?

17 A. Yeah.

18 Q. Okay. And Dr. Ambroise, as far as you can tell,
19 didn't even order a blood gas from the baby, correct?

20 A. Which speaks to the ability and vigor of this
21 baby, correct.

22 Q. Or maybe to the ability to not know what the
23 true status of the baby was at birth, right?

24 A. Well, no one but Dr. Ambroise --

25 MS. WIDLANSKY: Form.

1 THE WITNESS: I would suspect that
2 Dr. Ambroise who is now charged with the
3 responsibility for this child, if she had felt
4 that there was an asphyxial issue would have
5 performed immediately a blood gas on this baby.
6 And it's the most accurate blood gas of all.
7 More accurate than a cord blood gas.

8 BY MR. SILVA:

9 Q. Why are cord gasses performed at all then?

10 A. That's the subject of a lot of controversy,
11 because it's like if you can get direct evidence why
12 would you get indirect evidence?

13 Q. Have you performed cord gasses in the past on
14 your patients?

15 A. Sometimes, yes.

16 Q. Why?

17 A. Well, it depends on the patient. If I think
18 it is going to affect clinical care of the baby, yes,
19 I will.

20 Q. In what circumstances would you order a cord
21 blood gas when you think it's going to affect the
22 clinical situation of the baby?

23 A. Well, if I thought the baby was asphyxiated
24 and it had a five minute APGAR score of less than five
25 I would order a blood gas.

1 Q. I'm talking about a cord gas.

2 A. That's what I'm talking about, cord gas.

3 Q. Okay. So, can you order a cord gas immediately
4 at birth from the umbilical cord?

5 A. You can -- it can be done any time until the
6 cord is tossed out.

7 Q. Well, isn't it more accurate to take the
8 specimen immediately at birth?

9 A. Well, we are talking about accuracy. The
10 most accurate thing is take a specimen from the baby.
11 Why are you taking the specimen from the cord when you
12 have got the baby there.

13 Q. Let's focus on the cord gasses, sir.

14 Isn't the most accurate cord gas a specimen
15 taken immediately before birth?

16 MS. WIDLANSKY: Form.

17 THE WITNESS: It depends on what you are
18 looking for.

19 BY MR. SILVA:

20 Q. Looking for the oxygenation of the child.

21 A. Then check the baby.

22 Q. Yeah?

23 A. Yeah, that's how they do it, they check the
24 baby. They put a little pulse oximeter on the baby
25 and you could take a sample of blood from the baby.

1 Q. So what information do you get from performing a
2 cord gas on your patients? What information?

3 A. The same information that comes out in a cord
4 gas from a baby, but it's more accurate if you get it
5 from the baby than from the cord.

6 And if Dr. Ambroise felt that the baby there
7 was a specific issue that would be assisting -- it
8 would be to her benefit and to the baby's benefit
9 certainly she could have gotten a fetal blood gas,
10 which she actually did, you know, at whatever time she
11 felt it was clinically indicated.

12 So I would have to say Dr. Ambroise and I
13 also thought the same way. This was a fairly vigorous
14 kid for a two pounder that was born, you know --

15 Q. And if you felt --

16 A. -- 12-weeks ahead of time.

17 Q. And if you felt there was a delay in the
18 performance of the C-section in this case, it would be to
19 your benefit not to order a cord gas, wouldn't it?

20 MS. WIDLANSKY: Form.

21 THE WITNESS: I don't understand your logic.

22 BY MR. SILVA:

23 Q. Well, if the cord gas shows the baby is
24 severally hypoxic with a negative base excess at birth,
25 that wouldn't be to your benefit, would it, Doctor?

1 MS. WIDLANSKY: Form.

2 MR. BLOOM: Join.

3 THE WITNESS: Would it be to my benefit when
4 the baby is the best reservoir for evaluation of
5 pH and base excess; why would a cord be a better
6 choice than to draw a sample from the baby
7 itself?

8 It makes -- it would be -- why would you pick
9 the less sensitive and specific parameter when
10 you've got the whole baby there?

11 BY MR. SILVA:

12 Q. Well, why, if you did a cord gas in this case
13 and the pH was 6.9 and the base excess was minus 25, that
14 wouldn't be to your benefit, would it?

15 MS. WIDLANSKY: Form.

16 THE WITNESS: There are many scenarios that
17 wouldn't be to my benefit, but there was never
18 any evidence, from what I saw, that this baby had
19 any sort of an asphyxial issue. It had 8-8
20 APGARs. The baby was out.

21 The doctor that's taking care of the baby and
22 respiratory therapist who was taking care of the
23 baby both had opportunities to draw blood for pH
24 and oxygenation that are far more accurate than a
25 cord pH.

1 As I mentioned before, if I thought it was
2 going to be the baby's benefit for its treatment,
3 sure, I would have no problem ordering a blood
4 gas.

5 But I certainly had -- I never thought this
6 deep about the scenario at the time it happened.
7 The baby looked good, so why draw a blood gas.

8 BY MR. SILVA:

9 Q. I see. And do you know when the intubation was
10 performed?

11 A. Not specifically.

12 Q. How would the intubation affect the oxygen
13 saturation and APGARs at one and five minutes if it was
14 performed immediately after birth?

15 MR. MITTELMARK: Object to form.

16 MS. WIDLANSKY: Join.

17 THE WITNESS: It would elevate the APGARs.

18 BY MR. SILVA:

19 Q. It would increase the APGARs?

20 A. Correct.

21 Q. Okay. So, an APGAR -- is an APGAR even useful
22 if there has been a medical intervention such as
23 intubation with oxygen delivery to the infant?

24 A. Of course it is because --

25 Q. How --

1 A. -- the purpose of the APGAR score is not what
2 you're insinuating. The purpose the APGAR is the
3 baby's transition from intrauterine life and
4 transitioning to extrauterine life.

5 And we all know a two pound weight premature
6 baby is going to have a tough go of it. This baby in
7 the spectrum of premature babies was a rock star. It
8 had 8-8 APGARs.

9 Many times babies have premature lungs and
10 possible infections and all the other problems
11 detailed in here, it's not uncommon for them to end up
12 being intubated because they're premature, and as
13 Dr. Ambroise indicated had Respiratory Distress
14 Syndrome.

15 Q. Okay. And this baby, again as we mentioned
16 earlier, had a pH of 7.2 one hour after birth, and a base
17 excess of minus 5.1 one hour after birth, right?

18 A. Correct.

19 MS. WIDLANSKY: Form.

20 BY MR. SILVA:

21 Q. Do you think that any of the physicians were
22 negligent in any way in oxygenating the child in that one
23 hour period from the birth up until the time that this
24 blood gas was drawn?

25 MS. WIDLANSKY: Objection to form.

1 MR. BLOOM: Join.

2 MS. WIDLANSKY: Outside the scope.

3 THE WITNESS: I have no opinion one way or
4 the other.

5 BY MR. SILVA:

6 Q. Have you seen any medical records that lead you
7 to believe that they fell below the standard of care in
8 oxygenating this child after birth?

9 MS. WIDLANSKY: Objection to form.

10 MR. PUYA: Form.

11 THE WITNESS: I previously answered I haven't
12 seen the -- I'm not a neonatologist.

13 BY MR. SILVA:

14 Q. So the jury understands, you did not order a
15 cord blood gas on this child, so we don't have the
16 benefit of those results, correct?

17 MS. WIDLANSKY: Form, asked and answered.

18 THE WITNESS: Correct.

19 BY MR. SILVA:

20 Q. All right. And neither you, nor Dr. Ambroise,
21 ordered a blood gas on this child immediately after
22 birth, so we don't have the benefit of those results,
23 correct?

24 MS. WIDLANSKY: Form.

25 THE WITNESS: We have the benefit of the

1 examination that showed APGARs of 8 and 8, but we
2 did not have a blood gas to show the status at
3 that time, correct.

4 BY MR. SILVA:

5 Q. Right. So, we have no idea what this baby's
6 base excess was immediately after birth because a blood
7 gas wasn't performed, true?

8 A. No. A blood gas is only one of many elements
9 that's used to determine what interventions are needed
10 by a baby.

11 Most of the interventions are actually not
12 based on the lab, but are based on the clinical
13 observation of a trained observer such as
14 Dr. Ambroise.

15 MR. SILVA: Move to strike, did not answer my
16 question.

17 BY MR. SILVA:

18 Q. My question was: We don't have the benefit of
19 knowing what the base excess was in this baby immediately
20 after birth because a blood gas was not drawn, correct?

21 A. No, you don't have the base excess, but you
22 also note that the clinical evaluation did not seem to
23 indicate a need to know that base excess or
24 Dr. Ambroise could have easily ordered a blood gas.

25 Dr. Ambroise could have ordered sodium

1 bicarbonate if she felt that the base excess was
2 greater than minus 16.

3 Q. And why did she order a blood gas one hour after
4 birth?

5 A. You'll have to ask Dr. Ambroise. I'm not a
6 neonatologist, and whatever protocol she chose to put
7 in place in terms of the treatment must have been
8 based on what she was seeing and thinking.

9 Q. So this blood gas that was the ordered
10 approximately one hour after birth, it could have been
11 ordered immediately after birth in the birthing room,
12 correct?

13 MS. WIDLANSKY: Form.

14 THE WITNESS: Correct. There was absolutely
15 nothing to stop Dr. Ambroise if she felt it was
16 clinically important to order it immediately. It
17 was no different -- it was done exactly the same
18 way just at a time where she felt it was needed
19 to be done.

20 BY MR. SILVA:

21 Q. Okay. So, this blood gas that was performed one
22 hour after birth, it could have been performed
23 immediately after birth if Dr. Ambroise had wanted to do
24 that, correct?

25 MS. WIDLANSKY: Form, asked and answered.

1 THE WITNESS: That's right, yeah.

2 BY MR. SILVA:

3 Q. So, the first evidence we have anywhere in this
4 medical record of this child's oxygenation level is one
5 hour after birth.

6 MS. WIDLANSKY: Form.

7 THE WITNESS: I have not had an opportunity
8 to review the baby's records, as I mentioned
9 before. The baby is the patient of Dr. Ambroise,
10 so I have not reviewed the records, so I don't
11 know one way or the other.

12 BY MR. SILVA:

13 Q. I understand. I want you to assume for me that
14 plaintiff's Exhibit number 10, which is the blood gas
15 performed one hour after birth, is the first laboratory
16 performed after birth.

17 Do you think it's within the standard of care to
18 do this one hour after birth in a premature child?

19 MS. WIDLANSKY: Objection to form. Mr. Silva
20 he has testified repeatedly --

21 MR. SILVA: No, he hasn't.

22 MS. WIDLANSKY: Yes, he has. He is not a
23 neonatologist, he was not caring for the baby
24 once it was born. That was -- the child was
25 under the care of the neonatologist. And you're

1 repeatedly asking him questions about the baby's
2 health status when he's already told you he
3 hasn't reviewed the records and he wasn't the
4 child's provider.

5 BY MR. SILVA:

6 Q. Are you aware of any other cord blood gasses or
7 blood gasses on this child prior to one hour after birth?

8 MS. WIDLANSKY: Form.

9 BY MR. SILVA:

10 Q. Other than what you have seen here today?

11 A. I have not had an opportunity see the medical
12 records of the baby. The baby was not my patient
13 after it was handed-off from the operative theater.

14 Q. If the records show that this was the first
15 blood gas performed on this baby after birth, one hour
16 after birth, would you have any reason to dispute that?

17 MS. WIDLANSKY: Form.

18 THE WITNESS: No, I have no basis to have any
19 opinions because, again, I've not had an
20 opportunity to, nor would I, generally review a
21 pediatric neonatology chart.

22 BY MR. SILVA:

23 Q. Are APGARs a subjective test?

24 A. Yes.

25 Q. Is this blood gas a subjective or objective

1 test?

2 A. Objective.

3 Q. Okay. I want you to a take look now at
4 plaintiff's Exhibit number 12, which is the Rapid
5 Response Team worksheet.

6 (Plaintiff's Exhibit No. 12 was marked for
7 identification)

8 (END OF VOLUME I)

NOT A CERTIFIED COPY

C E R T I F I C A T E

I, ELEANOR M. EVENSEN, Registered
Professional Reporter, certify that I was authorized
to and did stenographically report the foregoing
proceedings and that the transcript is a true and
complete record of my stenographic notes.

Dated this 19th day of August, 2013.



ELEANOR M. EVENSEN, RPR, FPR
COURT REPORTER
377043

IN CIRCUIT COURT OF THE FIFTEENTH JUDICIAL
CIRCUIT IN AND FOR PALM BEACH COUNTY, FLORIDA

CASE NO. 2012CA020960XXXXMBAA

DOMINIC J. SHELTON, a minor, by and through
his parents and natural guardians, HEATHER
MCCANTS and BILLY SHELTON, and HEATHER MCCANTS
and BILLY SHELTON, individually,

Plaintiffs,

-vs-

BERTO LOPEZ, M.D.; LISA M. SANCHES, M.D.;
OB GYN SPECIALISTS OF THE PALM BEACHES, PA;
KERRY S. LANE, M.D.; ANESTHESIA AND CRITICAL
CARE SPECIALISTS OF PALM BEACH, PA; TENET
ST. MARY'S INC. D/B/A ST. MARY'S MEDICAL
CENTER, a Florida corporation,

Defendants.

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CONTINUATION VIDEOTAPED DEPOSITION OF BERTO LOPEZ, M.D.

TAKEN ON BEHALF OF THE PLAINTIFFS

Thursday, October 17, 2013
10:06 a.m. - 2:13 p.m.

515 N. Flagler Drive
Suite 1701
West Palm Beach, Florida 33401

Reported By:
Kathleen Lusz, RPR
Notary Public, State of Florida
Job#3969

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1 CONTINUED VIDEOTAPED DEPOSITION OF BERTO LOPEZ, M.D.

2 OCTOBER 17, 2013

3 - - -

4 THE VIDEOGRAPHER: Today's date is October 17,
5 2013. The time on the video monitor is 10:06 a.m.

6 MR. SILVA: Swear the witness.

7 Thereupon,

8 BERTO LOPEZ, M.D.,
9 having been first duly sworn, was examined and testified
10 as follows:

11 DR. LOPEZ: I do.

12 CONTINUED DIRECT EXAMINATION

13 BY MR. SILVA:

14 Q. Good morning. This is a continuation
15 deposition from August 9, 2013.

16 I want to clarify a couple things at the
17 outset. If you recall, we were discussing your
18 discharge summary, which I've previously marked as
19 Plaintiff's Exhibit Number 2. And I asked you some
20 questions about whether you had signed this form or not.
21 And I believe you testified that you had not signed it;
22 do you recall that?

23 A. Yes, that's correct. I did not put a wet
24 signature on this form.

25 Q. Okay. Now, I want you to look at the very

1 bottom of this page where it says authenticated by
2 Berto Lopez on February 26, 2011 at 12:48 in the
3 afternoon. Do you see that?

4 A. Yes.

5 Q. Is that considered an electronic signature --

6 A. Yes.

7 Q. -- at St. Mary's Medical Center?

8 A. It's considered an electronic authentication,
9 correct.

10 Q. Okay. I'll take that.

11 I'm going to mark now what will be Plaintiff's
12 Exhibit Number 14.

13 (Plaintiff's Exhibit Number 14 was marked for
14 identification.)

15 BY MR. SILVA:

16 Q. Take a look at it. And can you identify that
17 document for me, sir?

18 A. Other than Exhibit 14, I'm not familiar with
19 this document.

20 Q. Okay. What's -- What's the title at the top
21 of the page?

22 A. It says on the top left OnGuard 2013. Access
23 denied, granted and other badge events.

24 Q. And who is that information for?

25 MS. WIDLANSKY: Form.

1 BY MR. SILVA:

2 Q. Does that have your name on it?

3 A. On the right section it says cardholder name,
4 it has details, event, date/time and device.

5 Q. Is your name anywhere on that form?

6 A. Yes, as the cardholder. Cardholder name is my
7 name.

8 Q. Berto Lopez?

9 A. Yes.

10 Q. Okay. And it appears here that at 3:30 in the
11 afternoon access was granted to the physicians' east
12 lot; do you see that?

13 A. Yes.

14 Q. And can you describe how you get access to
15 this hospital with regards to parking in the physicians'
16 parking lot? Do you have to use some sort of card or an
17 access code?

18 A. Yes. We use an identifying badge. And I mean
19 even though it may be from another hospital, they're
20 somewhat similar. I think I still have one from this
21 morning.

22 Yeah. Here is my St. Mary's access badge. It
23 has a magnetic strip. And I generally park in the east
24 physicians' parking lot which faces Greenwood Avenue.

25 And in order to be -- There is an automatic

1 wooden arm that goes down. You have to swipe your badge
2 into a magnetic reader. And then if you're identified
3 and approved, the arm goes up, you park your car, and
4 you go inside --

5 Q. Okay.

6 A. -- the hospital.

7 Q. Okay. Do you use that same card to access the
8 Good Samaritan physicians' parking lot?

9 A. The St. Mary's parking lot.

10 No, you use a different one for Good Sam.

11 Q. Okay.

12 A. This one is for St. Mary's.

13 Q. It's specifically for St. Mary's?

14 A. Yes. Each hospital has their own badge.

15 Q. Okay. And so on that day when you were called
16 to come to the hospital for Heather McCants, you would
17 have come to the east physicians' parking lot?

18 A. Correct.

19 Q. And then you would have swiped your card?

20 A. Yes.

21 Q. And is that what this document shows that you
22 swiped your card at 3:30 in the afternoon?

23 MS. WIDLANSKY: Object to the form.

24 THE WITNESS: That's what it appears to say,

25 yes.

1 BY MR. SILVA:

2 Q. Okay. And then after that the next time entry
3 on this document states that 13 OB in R/0-3-14-2 access
4 granted to Berto Lopez.

5 Do you know what that stands for? Would that
6 be --

7 A. At 3:30 p.m.?

8 Q. Yes, sir.

9 A. That appears to be 13 OB into R/0-3-14-2
10 access granted. While I cannot say with certainty,
11 because I'm not involved with the badge system at
12 St. Mary's, it's probably when I badged into the labor
13 and delivery unit, the doors by the elevator --

14 Q. Okay.

15 A. -- to get into the labor and delivery area.

16 Q. Okay. And I guess my next question is going
17 to be once you park your car in the east physicians'
18 parking lot at St. Mary's Medical Center, how do you
19 gain access to the hospital normally?

20 A. I go in through the Greenwood Avenue entrance,
21 walk in, passed the security checkpoint which is not
22 badged --

23 Q. Okay.

24 A. -- go to a bank of elevators. And the
25 entrance is on the ground floor. So you hit one to go

1 to the first floor, which is where labor and delivery is
2 in. And then I would badge into access controlled doors
3 that allow me into the labor and delivery area.

4 Q. Okay. And then there is an entry here at 3:37
5 p.m. that also says 13 OB R/0-3-14-2. Can you tell us
6 why this system would have captured your badge again at
7 3:37?

8 MS. WIDLANSKY: Form.

9 THE WITNESS: And, again, I'm not an expert on
10 what this form stands for.

11 But I re-badged in, as I mentioned before, I
12 went to the elevator bank after waiting for
13 Ms. McCants to be brought down from the second
14 floor, the antepartum area, to the first floor
15 where the OB/OR is. I walked to the bank of
16 elevators.

17 BY MR. SILVA:

18 Q. I gotcha.

19 A. And then I re-badged into the OB/OR preop
20 area.

21 Q. Okay. So that would explain a badging into
22 the L&D area at 3:33 and then a second reentry at 3:37,
23 approximately four minutes later?

24 A. That's right.

25 Q. Okay. And then the next time that access was

1 granted appears to be OB out at 4:15 in the afternoon?

2 A. Yes.

3 Q. Is that the time that you would have left the
4 facility?

5 A. That would have been my badging out of the
6 OB delivery area, which would include the OB/OR area, to
7 go back to the bank of elevators to go back to the
8 first -- the ground floor to go out to the parking lot
9 to go to my car.

10 Q. Okay.

11 A. At least that's my interpretation of that.

12 Q. Does that -- Does this document help refresh
13 your recollection of what happened that day?

14 A. Only I would say it's an independent record
15 electronically of my badging in and badging out behavior
16 if that is, in fact, certified as the hospital's badging
17 record.

18 Q. Okay. Did you -- As you sit here today, do
19 you know if you ever looked at the electronic medical
20 records for the nurses notes for Heather McCants on
21 January 26, 2011?

22 A. No, I did not.

23 Q. Okay. I'm going to have you take a look at
24 what I'm going to mark as Plaintiff's Exhibit Number 15.

25 (Plaintiff's Exhibit Number 15 was marked for

1 identification.)

2 BY MR. SILVA:

3 Q. Prior to this case, have you had occasion to
4 look at electronic nurses notes at St. Mary's Medical
5 Center?

6 A. Yes.

7 Q. Okay. Does that look familiar to you as
8 entries that nurses make into the medical record?

9 A. Yes.

10 Q. Okay. And according to this first page on
11 Plaintiff's Exhibit Number 15, is there a timed entry
12 there for a nurses note on January 26th at 12:15 in the
13 afternoon?

14 A. Yes.

15 Q. And it says call for PICC Team, no answer. Do
16 you see that?

17 A. Yes.

18 Q. Were you involved in any of the issues with
19 the PICC line being clotted prior to your call from the
20 Rapid Response Team?

21 A. No.

22 MS. WIDLANSKY: Form.

23 BY MR. SILVA:

24 Q. Then at 12:40 there is a nursing entry here
25 that states: Left message for the PICC Team. Do you

1 see that?

2 A. Yes.

3 Q. Okay. Turn to the next page, please.

4 At 1:00 in the afternoon on January 26th
5 there's a nursing entry: Notified Carol Seamon that
6 PICC Team was has not answered. Do you see that?

7 A. Yes.

8 Q. Did you ever have any conversations with Nurse
9 Carol Seamon regarding any of the issues of the PICC
10 line being occluded?

11 A. No, not that I can recall.

12 Q. Okay. Or any issues with them having
13 difficulty in getting the PICC line team to come address
14 the occluded PICC line?

15 A. No.

16 MS. WIDLANSKY: Form.

17 BY MR. SILVA:

18 Q. The next entry in this nurses note that you're
19 looking at is January 26th, 2:40 in the afternoon, and
20 it says: Call to Patrick, PICC Team.

21 Do you know a Patrick on the PICC Team at this
22 hospital?

23 A. I don't personally know of Patrick. I have I
24 believe spoken to Patrick on the PICC line team. He's a
25 nurse that does line placements.

1 Q. Okay. Do you have occasion to order PICC
2 lines on your patients occasionally at this hospital?

3 A. Yes.

4 Q. And how do you go about doing that?

5 A. Generally speaking -- Well, it's kind of a
6 then and now. Back then you would write the order. Or
7 if you wanted it with some sort of expeditious response,
8 you would call for the PICC line nurse and then speak to
9 them and explain to them what your needs were. And then
10 they would express how they were going to satisfy those
11 professional needs.

12 Q. Okay. When you ordered a PICC line for a
13 patient, do you recall if there is a specific protocol
14 on the chart back in 2011 that you had to fill out with
15 regards to the maintenance of the PICC line?

16 A. Since it's 2011 and we're talking about 2013,
17 I don't remember specifically.

18 Q. Okay. The next entry is at on this electronic
19 nurses note 3:05, and it states: Patrick at the bedside
20 administered Cathflo in both PICC ports.

21 My question to you is after this incident
22 occurred, did you have any conversations with any of the
23 health care providers as to why the Cathflo needed to be
24 injected at 3:05 on January 26th?

25 MR. MITTELMARK: Object to the form.

1 BY MR. SILVA:

2 Q. Go ahead.

3 A. I don't recall specifically. I know that I
4 never spoke to Patrick. I remember having a
5 conversation with Nurse Duckworth. And my understanding
6 was that the PICC line had occluded, and they were going
7 to flush them as they do routinely if there is an
8 occluded PICC line.

9 Q. Okay. Was that in the initial conversation
10 that you had with Janis Duckworth on the phone?

11 A. Yes. And that would have been like after the
12 rapid response --

13 Q. Okay.

14 A. -- had occurred.

15 Q. Okay. You didn't have any conversations with
16 Janis Duckworth on that date prior to the Rapid Response
17 Team being called?

18 A. That's correct. Because Dr. Tum, as was
19 indicated in one of these notations, made rounds in the
20 antepartum patients for our group.

21 Q. Okay. Do you know if Dr. Tum was still in the
22 hospital at the time that the Rapid Response Team was
23 called?

24 A. No, I don't.

25 Q. Do you know if Janis Duckworth attempted to

1 call Dr. Tum prior to you being called on January 26,
2 2011?

3 A. I don't know.

4 Q. The next entry in this electronic nurses note
5 is at 3:06. It states: Patient complains of shortness
6 of breath immediately following Cathflo administration.

7 Is that your understanding of what
8 Janis Duckworth told you that this patient had an
9 immediate reaction to the Cathflo injection?

10 A. Or something --

11 MR. MITTELMARK: Object to the form.

12 BY MR. SILVA:

13 Q. You can answer.

14 A. Or something consistent with that. I don't
15 remember exactly what she said.

16 Q. I'll take that one. Thank you.

17 Next I'm going to mark Plaintiff's Exhibit
18 Number 16, which is the perioperative nursing note.
19 (Plaintiff's Exhibit Number 16 was marked for
20 identification.)

21 BY MR. SILVA:

22 Q. Just take a look at that, sir. And then I'm
23 going to ask you some questions.

24 Whenever you're done, just let me know.

25 A. Okay. I'm ready.

1 Q. Okay. Back on January 26, 2011 were
2 physicians notes at this hospital and progress notes and
3 physicians orders in paper form?

4 A. Yes.

5 Q. Okay. Did you as a physician, as an OB/GYN,
6 ever enter any information into the electronic medical
7 record back in January of 2011?

8 A. Not to my recollection.

9 Q. So what we're looking at here is a
10 perioperative nursing note. It appears the author is
11 Josephine Braga. It's in electronic form.

12 Do you know who entered this information into
13 this document?

14 A. Know by independent knowledge, no. But I
15 would assume since it's been recorded as Josephine
16 Braga, stored by the Josephine Braga, RN, on the top
17 left of the page that she was an author of the note.

18 Q. And it has an area here where it says last
19 stored at 4:21 on January 26th. Do you see that?

20 A. Yes.

21 Q. Is there any indication on this form that
22 would lead you to conclude that any entries were made at
23 6:23 in the afternoon on January 26th to this record?

24 MR. MITTELMARK: Object to the form.

25 MS. WIDLANSKY: Form.

1 BY MR. SILVA:

2 Q. You can answer.

3 A. No.

4 Q. Okay. The -- According to this document it
5 states: Transported to OR: Bed. Does that -- What
6 does that mean, that she's transported in the same bed
7 she was in?

8 A. Yes. As opposed to a stretcher.

9 Q. Okay. And then transport by RN.
10 Does it identify which RN transported the
11 patient?

12 A. No.

13 Q. It says that OR room number two. Does that
14 refer to the OB/OR or the main OR?

15 A. This is the OB/OR. There is two OB/ORs: Room
16 one and room two. This case occurred in room two.

17 Q. Okay. And then next case type it has urgent.

18 A. Correct.

19 Q. Do you see that?

20 Do you know who directed Josephine Braga to
21 enter a case type urgent in this form?

22 MS. WIDLANSKY: Form.

23 THE WITNESS: Probably me.

24 BY MR. SILVA:

25 Q. And it says scheduled OR time: Patient in the

1 OR at -- Is that 1537?

2 A. That's what I interpret that as, yes.

3 Q. Okay. So that would be in laymen's terms 3:37
4 in the afternoon?

5 A. Yes.

6 Q. As you sit here today, do you know where
7 Heather McCants was from the time that the C-section was
8 called until 3:37?

9 A. In a general way I knew that she was in her
10 room. Then she was transported down the hallway, took
11 elevators down from the second floor to the first floor,
12 and then was brought to the preop area in front of the
13 operating rooms before she was wheeled into the
14 operating room.

15 Q. Okay. Have you ever used your cell phone in
16 an OB operating room at St. Mary's Medical Center?

17 A. No.

18 Q. Have you ever attempted to?

19 A. Yes, but the reception was unacceptable.

20 Q. Okay.

21 A. I have AT&T. I don't know if it's any better
22 with somebody else.

23 Q. Okay. So your cell phone carrier is AT&T?

24 A. Yes.

25 Q. Have you attempted to make a cell phone call

1 from your AT&T cell phone prior to today in either one
2 of the OB/ORs at St. Mary's Medical Center?

3 A. Not in -- Not to my recollection. But things
4 have changed. I mean, you know, now they've upgraded to
5 a 4G system, whatever that means, and then a 4G LTE.

6 So I don't know what type of system, meaning
7 how many towers and what the strength of the signal was.
8 But --

9 Q. Sure.

10 A. -- prior to approximately 2011, it wouldn't go
11 through. Phone messages and text messages wouldn't go
12 through, phone calls wouldn't go through.

13 Q. Okay. Do you know if the OB operating rooms
14 are leaded?

15 A. No, I don't know that.

16 Q. Okay. Do you perform x-rays in the operating
17 room?

18 A. Sometimes.

19 Q. According to this document, the anesthesia
20 start time and date is January 26, 2011 at 3:37. Do you
21 see that?

22 A. Yes.

23 Q. And then the incision time according to this
24 document is at 3:51?

25 A. Yes.

1 Q. And the preop diagnosis was fetal,
2 nonreassuring status?

3 A. Yes.

4 Q. Do you know how Josephine Braga -- where she
5 got that knowledge to put that information into this
6 document?

7 MS. WIDLANSKY: Form.

8 THE WITNESS: Not exactly, no.

9 BY MR. SILVA:

10 Q. Do you know if that was an assessment she made
11 herself or if a physician directed her to put that preop
12 diagnosis in?

13 A. I would be speculating. I think we could ask
14 Nurse Braga.

15 Q. Okay. As an OB/GYN what does a fetal
16 nonreassuring status mean; do you know?

17 A. It means that the baby is in an environment
18 that it needs to be taken away from. In other words,
19 the baby is inside the mother's womb, and it's not
20 demonstrating the signs of fetal well-being such that it
21 needs to be removed by operation.

22 Q. It means the operation, the C-section?

23 A. Cesarean section, yes. C-section.

24 Q. And then the postop diagnosis, was that the
25 same: Fetal, nonreassuring status?

1 A. Yes.

2 Q. What -- What's the reason for entering in --
3 this information into the medical record preop where it
4 says postop diagnosis?

5 A. First of all, documentation of the reason or
6 indication for surgery is a standard nursing
7 documentation obligation, both for billing and coding
8 and for the health care processes to be understood by
9 other members of the health care team.

10 And postop diagnosis, sometimes it matches up
11 with the preop, sometimes it doesn't depending on the
12 circumstances.

13 Q. Okay. In this case the postop diagnosis was
14 still fetal, nonreassuring status, correct?

15 A. Yes.

16 Q. And then the operation, what is documented
17 here?

18 A. Non-scheduled primary cesarean.

19 Q. Okay. And that -- that's to distinguish this
20 surgery from a scheduled primary cesarean section?

21 A. Correct.

22 Q. And a scheduled primary cesarean section would
23 be something that's planned ahead of time with the
24 patient and the physician and the staff?

25 A. Correct. It's a scheduled, planned C-section.

1 You have an appointment to have your baby delivered.

2 Q. And then the anesthesia type used states
3 spinal Astramorph?

4 A. Yes.

5 Q. What does that mean to you as an OB?

6 A. It's a subarachnoid injection of medication
7 called Astramorph, which is long-acting pain medication
8 that's administered to alleviate pain and discomfort for
9 about 24 hours.

10 Q. The surgeon is yourself, right?

11 A. Yes.

12 Q. And this documents that you came into the room
13 at 3:50?

14 A. Yes.

15 Q. And that you left at 4:05?

16 A. Yes.

17 Q. And then it states that there were some
18 assistants there, a Milsa Amely?

19 A. Yes.

20 Q. Does she or he work with you?

21 A. She is a registered nurse first assistant who
22 has assisted me on hundreds of cesarean sections.

23 Q. Is she a hospital employee?

24 A. She is.

25 Q. And then underneath that there is Dr. Tum. Do

1 you see that?

2 A. Yes.

3 Q. It states that these two providers came into
4 the room also at 3:50?

5 A. Yes.

6 Q. Do you see that?

7 A. Yes.

8 Q. Is that your recollection, that Dr. Tum came
9 into the room at the same time you did?

10 A. No. Initially Dr. Tum was in transit to the
11 hospital so -- As I recall. And Milsa Amely, Nurse
12 Amely, assisted me until Dr. Tum arrived.

13 Q. Did Dr. Tum arrive before or after the baby
14 was delivered?

15 A. That I don't recall.

16 Q. You were able to get the baby out in one
17 minute from the time that the procedure started, right?

18 A. If that's what the record indicates. You
19 know, when you're actually performing these things,
20 you're -- I'm not the one documenting times. I'm more
21 interested in taking care of the patient.

22 Q. In a -- in a stat C-section can you get a baby
23 out in a minute once you start the procedure?

24 A. Theoretically if it was a stat C-section, yes.

25 Q. Okay.

1 A. But I also routinely in a scheduled C-section
2 would get a baby out in about the same amount of time.
3 My technique is called the -- It's a Swedish method
4 where I use blunt dissection rather than sharp
5 dissection. And I don't do anatomic separation of
6 peritoneal surfaces such as the abdominal peritoneum and
7 the parietal peritoneum.

8 Q. And what -- Do you know what kind of --
9 Do you recall what kind of a surgical approach
10 you used? Did you use a vertical incision or --

11 A. No. I used a low transverse incision.

12 Q. Okay. According to this document, did you
13 have any difficulty in delivering the baby once you
14 started the procedure?

15 A. According to this document, it doesn't
16 indicate one way or the other. But I don't recall any
17 technical factors other than, as I mentioned before,
18 Ms. McCants was 350 pounds and five foot maybe two. And
19 I believe her abdomen had to be taped up in the manner
20 which they typically do when patients have a -- what we
21 call a panniculus, which is -- which is abdominal drape
22 of -- of skin that would cover over the typical incision
23 site.

24 Q. Sure. But if these medical records state that
25 the incision time started at 3:51 and the baby was

1 delivered at 3:52, would you have any reason to dispute
2 that?

3 A. No.

4 MS. WIDLANSKY: Form.

5 BY MR. SILVA:

6 Q. The doc -- This document states that the
7 anesthesiologist, Kerry Lane, came into the room at
8 3:57. Do you see that?

9 A. Yes.

10 MR PUYA: Object to the form.

11 MR. SILVA: And --

12 MR PUYA: 3:57?

13 MR. SILVA: Strike that.

14 BY MR. SILVA:

15 Q. This document states that anesthesiologist,
16 Kerry Lane, came into the room at 3:37?

17 A. I stand corrected as well, yes.

18 Q. Yes, thank you.

19 And it states that you left the room at 4:00?

20 A. Yes.

21 Q. Do you know if there were any other
22 anesthesiologists in the room from 4:00 until 4:05,
23 until the time that you left the room?

24 A. I do not know from recollection.

25 Q. Okay. Does this document show that any CRNA

1 was in the room from 4:00 until 4:05?

2 A. Since I'm not the author of this article --
3 I'm sorry, of this document, I don't see an indication
4 that there was.

5 Q. Well, there is an area there for CRNA. Is
6 that blank?

7 A. Yes.

8 Q. And then it has circulator, Josephine Braga,
9 time in the room at 3:37?

10 A. Yes.

11 Q. And do you know a Nurse Braga?

12 A. Yes.

13 Q. And it appears Barbara Akan also came into the
14 room at 3:37. Do you know that nurse?

15 A. Yes.

16 Q. And what about Marie Taylor?

17 A. Yes.

18 Q. She came into the room also at 3:37?

19 MS. WIDLANSKY: Form.

20 THE WITNESS: That would -- I have no
21 recollection. I'm not the author of this note.

22 BY MR. SILVA:

23 Q. But according to this document?

24 A. Yes. According to this document, that's what
25 it says.

1 Q. Do you recall -- Do you know a Marie Ambroise?

2 A. Yes, Dr. Ambroise.

3 Q. What kind of doctor is she?

4 A. I'm told she's a pediatrician who specializes
5 in neonatologist.

6 Q. Do you recall --

7 A. Neonatology, excuse me.

8 Q. Do you recall if she was in the room at the
9 time that the baby was delivered?

10 A. I don't know. Because, again, I was doing
11 what I was doing and not really clocking in and
12 seeing -- I was not the author of this note so I cannot
13 say one way or the other if -- if she was in the room as
14 indicated or not.

15 I do remember that she was in the room when
16 the baby was born.

17 Q. Do you know what time these entries were put
18 into this electronic medical record?

19 A. No.

20 Q. Do you know if Josephine Braga met with Risk
21 Management before she entered these times into this
22 document?

23 A. No.

24 Q. I'll take that. Thank you.

25 Next document I'm going to have you look at is

1 a cesarean section preop order, which I'm going to mark
2 as Plaintiff's Exhibit Number 17.

3 (Plaintiff's Exhibit Number 17 was marked for
4 identification.)

5 BY MR. SILVA:

6 Q. Can you identify this document for me?

7 A. Yes. This is a preop order sheet, which is a
8 standardized order sheet.

9 Q. Is this a physician's order sheet that has to
10 be filled out and signed --

11 A. Yes.

12 Q. -- prior to any surgical procedure?

13 A. Yes.

14 Q. And is your writing anywhere on this document?

15 A. Yes. The date and the signature are my
16 writing.

17 Q. Okay. And do you see an area there where it
18 says date, forward slash, time?

19 A. Yes.

20 Q. And did you time this document?

21 A. No, I did not.

22 Q. Do you know at what time you signed this
23 document?

24 A. No, I do not.

25 Q. Can you tell me what your preop orders were?

1 A. They are as indicated on this page, including
2 the check mark for the CBC and the 2 grams of IV Ancef
3 push to be --

4 If you want me to run -- Do you want me to run
5 through every one of the orders?

6 Q. Well, yeah, you can start from the top and go
7 on.

8 A. Okay. Number one was admit to inpatient
9 status.

10 Number two was NPO.

11 Number three, IV Lactated Ringers at 150
12 milliliters per hour.

13 Number four, CBC, type and screen.

14 Number five, medications: Ancef, which is
15 cefazolin, two grams IV, one dose before OR.

16 Number six, clip and prep in operating room at
17 surgeon's discretion.

18 Number seven, number 16 Foley with five
19 milliliter balloon. Patient may request placement in
20 OR.

21 Number eight, check for consent. If not
22 present, please place one on front of chart.

23 Number nine, Alka Seltzer Gold two tabs PO in
24 30 milliliters of water or Bicitra 30 milliliters preop
25 times one.

1 Number ten, anesthesia to preop.

2 Number eleven, sequential compression devices
3 to OR.

4 Q. Okay. Do you know if these -- If your orders
5 were actually carried out prior to the procedure?

6 A. I believe they were.

7 Q. Do you know when the CBC was ordered and
8 drawn?

9 A. Since she was an inpatient being monitored for
10 prolonged rupture of membranes, I don't know whether one
11 was done specifically that day. But she was having them
12 done serially.

13 Q. Okay. But your order was to perform a CBC,
14 right?

15 A. Correct.

16 Q. Do you know if the nurses performed it?

17 A. No, I don't. I don't have independent
18 recollection.

19 Q. Okay. You also had an order to give Ancef
20 two grams IV one dose before the operating room. Do you
21 know if the nurses did that?

22 A. I do not know.

23 Q. What was your reason for ordering Ancef two
24 grams IV one dose before the OR?

25 A. There were several. The main reason is it's a

1 prophylactic antibiotic to diminish the risk of a
2 surgical site infection.

3 Q. Do you know how long it takes to administer
4 two grams of IV of Ancef?

5 MS. WIDLANSKY: Form.

6 THE WITNESS: I don't know like in minutes and
7 seconds, but it doesn't take very long.

8 BY MR. SILVA:

9 Q. Have you ever read the product insert for
10 cefazolin?

11 A. Probably not since it came out.

12 Q. Would you disagree with any of the product
13 recommendations on the product insert for the
14 antibiotic?

15 MS. WIDLANSKY: Form.

16 MR. MITTELMARK: I'll join.

17 THE WITNESS: You mean specifically in regards
18 to Ancef or in general? Since --

19 BY MR. SILVA:

20 Q. No in --

21 A. -- one of my former professors was on the FDA
22 committee for medications. I can tell you that many of
23 the items that are included in the product insert are
24 boilerplate and are the same across the board for many
25 medications and do not necessarily reflect the usage of

1 a medication at the time of a clinical situation.

2 In other words, when they're passed -- When a
3 drug is approved by the Food and Drug Administration,
4 the product insert is approved by the Food and Drug
5 Administration and the regulators thereof. And they're
6 only updated periodically. So the product insert may be
7 several years old relative to the advancement of how we
8 practice medicine.

9 Q. Do you think that doctors can ignore product
10 inserts for medications?

11 MS. WIDLANSKY: Form.

12 THE WITNESS: It depends on the medication.
13 And it depends on the basis of science for which
14 the doctors are using the medication.

15 BY MR. SILVA:

16 Q. Do you have any personal knowledge or any
17 research experience in -- in how product inserts are
18 created for medications?

19 A. As I said, when I was a resident, one of my
20 professors was on the FDA committee and gave a lecture
21 on the Food and Drug Administration approval of
22 medication process. Her name was Elizabeth Connell,
23 M.D.

24 Q. How many years ago was that?

25 A. I was a resident from '83 to '87.

1 Q. Okay. And this incident occurred in the year
2 2011?

3 A. Yes.

4 Q. So approximately 20 -- 20-some-odd years
5 later?

6 A. Right.

7 Q. Do you know what the FDA has done with regards
8 to product inserts in that 20-some-odd-year interim?

9 A. Well, actually a week ago I had one of my
10 students ask me a question about product inserts. And
11 we opened one up about a birth control pill. And the
12 product insert was dated as being approved something
13 like four years prior to the date that we reviewed the
14 insert. So if it was dated as approved on a certain
15 date, it was certainly standing four years later.

16 Q. Do you know when the date of approval for the
17 product insert for the Ancef that you ordered the nurses
18 to give on January 26, 2011 was approved?

19 A. No, because I didn't check the insert on the
20 vial that was administered.

21 Q. The first thing on this order says admit to
22 inpatient status. What does that mean?

23 A. That means that if the patient, for example,
24 is coming in for a scheduled C-section that her
25 electronic status in the hospital system is converted to

1 inpatient status. This would not apply to Ms. McCants
2 because she had already been previously admitted to
3 inpatient status.

4 Q. Do you know if any work had to be done in
5 registration at St. Mary's to convert Heather McCants
6 from a prenatal patient to a patient that was going to
7 have surgery?

8 MR. MITTELMARK: Object to the form.

9 THE WITNESS: I would not know as she was
10 already an inpatient.

11 BY MR. SILVA:

12 Q. Do you know if the patient identification has
13 to be changed when she is moved from the prenatal unit
14 to the operating room?

15 MR. MITTELMARK: Object to the form.

16 THE WITNESS: No, I do not know that
17 procedure.

18 BY MR. SILVA:

19 Q. Do you know how long that procedure takes?

20 A. I'm not sure that -- that a procedure is
21 involved if the patient is already inpatient admitted as
22 an antepartum that any procedure has to be enacted at
23 all.

24 Q. When you first saw Heather McCants, she was
25 already in the operating room?

1 A. No. When I first saw Heather McCants, she was
2 an antepartum patient who I accepted as a transfer.

3 Q. Okay. I'll be more specific. On January 26,
4 2011 was the first time that you saw Heather McCants
5 when you entered the operating room?

6 A. No. I saw Ms. McCants in the preop area
7 before we entered the operating room.

8 Q. At what time did you first see
9 Heather McCants?

10 A. I don't recall that I recorded a time.

11 Q. Was it before or after 3:37 in the afternoon?

12 MS. WIDLANSKY: Form.

13 THE WITNESS: It would have to be after.

14 MR. SILVA: I'll take that one.

15 THE WITNESS: Okay.

16 BY MR. SILVA:

17 Q. The next document I'm going to have you look
18 at is the surgery anesthesia perioperative assessment.

19 (Plaintiff's Exhibit Number 18 was marked for
20 identification.)

21 BY MR. SILVA:

22 Q. Just review it, and then let me know when
23 you're done.

24 A. Okay.

25 Q. Is -- First of all, can you identify this

1 document for me?

2 A. It's labeled surgery anesthesia perioperative
3 assessment, two pages.

4 Q. Okay. Is your handwriting anywhere on this
5 document?

6 A. No.

7 Q. Do you know who filled this document out?

8 MS. WIDLANSKY: Form.

9 THE WITNESS: I recognize the signature of
10 Dr. Lane on January 26, 2011. And then it looks
11 like his handwriting.

12 BY MR. SILVA:

13 Q. And can you tell at what time this document
14 was signed at?

15 A. No. No.

16 Q. There is an area there that says 1530 right
17 above the signature page --

18 A. Yes.

19 Q. -- and the date of 1530. Is that 3:30 in
20 laymen's terms?

21 A. Yes.

22 Q. And then there is an area here for assessment,
23 American Society of the Anesthesiologists Class.

24 Do you ever get involved in assigning
25 patients' ASA ratings?

1 A. No.

2 Q. You leave that to the anesthesiologist?

3 A. Role, yes.

4 Q. There is an area there, number one, that's
5 circled and then crossed out. Do you know why that's
6 crossed out?

7 A. No.

8 Q. Do you know who crossed that out?

9 A. No.

10 Q. And then there's an area there circled three
11 and "E". Do you know what "E" stands for?

12 A. No.

13 Q. Have you ever had any discussions throughout
14 your career with any anesthesiologists where you gained
15 the knowledge that "E" stands for emergency?

16 A. No.

17 Q. And according to the first page of this
18 document, the procedure is C-section, repeat for fetal
19 distress?

20 A. Correct.

21 Q. Do you know how Dr. Lane gained the knowledge
22 that Heather McCants' baby was in fetal distress?

23 A. No.

24 Q. Did you have any conversations with Dr. Lane
25 where you told him that you were performing a C-section

1 for fetal distress?

2 A. I don't have an independent recollection of
3 our conversation.

4 Q. There is an area here on review of systems on
5 the first page for respiratory. And it's circled
6 negative. Do you see that?

7 A. Yes.

8 Q. Okay. Is there anything on that document that
9 states that Heather McCants suffered a respiratory
10 arrest?

11 A. No.

12 MR PUYA: Form.

13 MS. WIDLANSKY: Join.

14 BY MR. SILVA:

15 Q. Is there anything on this document that states
16 that Dr. Lane had a discussion with Heather McCants
17 about general anesthesia versus subarachnoid block?

18 A. Specifically, no. However, it does say on the
19 second page in the bottom quadrant
20 risk/plan/alternatives discussed. Questions answered.
21 Patient/guardian agrees to proceed as planned. And
22 that's I think signed by Dr. Lane.

23 Q. And do you know what discussions Dr. Lane had
24 with Heather McCants regarding the alternatives to
25 subarachnoid block?

1 A. No, I do not.

2 Q. There's an area here on the second page class
3 one, two, three and four of Mallampati class. Do you
4 know what that is?

5 A. No, I do not.

6 Q. Is there anything circled there with regards
7 to class one, two, three or four?

8 A. No.

9 Q. Is there anything entered in regarding
10 Heather McCants dentition?

11 It's right below it.

12 A. Oh, no. I see it now, yes. No.

13 Q. Or any -- anything entered in regarding
14 Heather McCants' neck range of motion?

15 A. No.

16 Q. And with regards to the history of difficult
17 intubation, what is the entry?

18 A. It's either O-K or -- This is my
19 interpretation of somebody else's handwriting. It's
20 either O-K or O-C with a slash. I don't interpret that
21 -- I'm many not sure how to interpret that.

22 Q. Okay. Yes is not checked off, is it?

23 A. No.

24 Q. Is there anything on this document that states
25 that Heather McCants could not undergo a general

1 anesthesia?

2 A. There's nothing one way or the other.

3 Q. I'll take that.

4 A. Yes.

5 Q. Thank you.

6 The next document I'm going to have you look
7 at is the anesthesia record of January 26, 2011.

8 (Plaintiff's Exhibit Number 19 was marked for
9 identification.)

10 BY MR. SILVA:

11 Q. Is your handwriting anywhere on this document?

12 A. No.

13 Q. And according to this document, the anesthesia
14 time is 3:37?

15 MR PUYA: Form.

16 THE WITNESS: I'm sorry. The anesthesia time
17 I see in the top left is -- Yes, it starts at 3:37
18 and then it's at 1636, which is -- I'm sorry.
19 1618, which is 4:18, yes.

20 BY MR. SILVA:

21 Q. There is a box for anesthesia time. It has
22 3:37 to 4:36. Do you see that?

23 A. Yes.

24 Q. And then it has surgery time, and it has 1551
25 to 1618. Do you see that?

1 A. Yes.

2 Q. Is there anything on this document that states
3 that anesthesia was given prior to 3:37?

4 A. No.

5 Q. Towards the right column halfway down there's
6 an area here that says antibiotics Ancef two grams start
7 at 1554. Do you see that?

8 A. Give me one second.

9 Q. Sure. I'll point it to you.

10 A. Okay.

11 Q. It's right there.

12 A. Yes.

13 Q. Okay. So according to this document, the
14 Ancef was not given preoperatively, was it?

15 A. No.

16 Q. It was given after the procedure at 1554?

17 A. Correct.

18 Q. Do you know what pre-induction means?

19 A. I have a general idea of what it means.

20 Q. Just as an OB tell me what your understanding
21 is.

22 A. Before the initiation of anesthesia.

23 Q. Are you talking about general anesthesia?

24 A. It doesn't have to be a general only.

25 Q. It can be any type of anesthesia?

1 A. Correct. The initiation of anesthesia in
2 doctor talk sometimes can be called the induction of
3 anesthesia, whether it's a spinal or whether it's an IV
4 sedation or whether it's an intubation.

5 Q. Okay. And I want you to look to the top
6 left-hand corner of this document. There is an area
7 that's checked off that says patient reevaluated
8 pre-induction. Can you tell us what time is entered
9 there?

10 A. 1538 or 3:38.

11 Q. Is there any information on this document
12 about the fetal heart rate?

13 A. Not that I can identify, no.

14 Q. And then it denotes that the anesthesiologist
15 is Lane and the surgeon is Lopez?

16 A. Yes.

17 Q. And it says OB/OR is that B?

18 A. Yes.

19 Q. And on the top right-hand corner of this
20 document there is an area there where it says chart
21 reviewed. Is that checked off?

22 A. Yes.

23 Q. Thank you.

24 The next document I'm going to have you look
25 at is -- The anesthesia note I just had you look at is

1 Exhibit Number 19.

2 And then the postoperative subarachnoid opioid
3 for cesarean section patients will be Number 20.

4 (Plaintiff's Exhibit Number 20 was marked for
5 identification.)

6 BY MR. SILVA:

7 Q. Can you take a look at that, sir?

8 Just let me know when you're done.

9 A. Okay.

10 Q. Okay. This is a postoperative subarachnoid
11 opioid order for cesarean section patients?

12 A. Correct.

13 Q. And does this appear to have been signed by
14 Dr. Lane?

15 A. Yes.

16 Q. On January 26, 2011?

17 A. Yes.

18 Q. Okay. At 3:30 in the afternoon?

19 A. Yes.

20 Q. Did you -- Were you in the presence of
21 Dr. Lane or Heather McCants at 3:30 in the afternoon?

22 MS. WIDLANSKY: Form.

23 THE WITNESS: I don't know.

24 BY MR. SILVA:

25 Q. This document, if you look at number one, it

1 states this patient received .3 milligrams of
2 Astramorph, morphine sulfate, and 15 micrograms of
3 Fentanyl by the subarachnoid route on 1/26 at 3:30 in
4 the afternoon.

5 Is that the anesthesia that was used in this
6 case so that you could perform a C-section?

7 A. Yes.

8 Q. Do you know how long it took Heather McCants
9 to be ready to be cut by a surgeon, such as yourself,
10 after she received the subarachnoid block on January 26,
11 2011?

12 MR. PUYA: Form.

13 THE WITNESS: No.

14 BY MR. SILVA:

15 Q. Do you know if there was any difficulty with
16 administering adequate anesthesia by the subarachnoid
17 block prior to performing the procedure?

18 A. No, I don't know.

19 Q. I'll take that. Thank you.

20 MR. SILVA: Ready for a five minute break?

21 MS. WIDLANSKY: Okay.

22 MR. SILVA: Let's go ahead and take a five
23 minute break.

24 THE VIDEOGRAPHER: Off the video record at
25 10:59.

(A recess was taken.)

THE VIDEOGRAPHER: We are now back on the
video record at 11:09.

(Plaintiff's Exhibit Number 21 was marked for
identification.)

BY MR. SILVA:

Q. I'm going to hand you Exhibit Number 21, which
is your operative report, sir. Just take a look at the
document.

A. Okay.

Q. When you are done, just let me know.

A. Okay.

Q. When did you dictate this operative report?

A. On January the 26th, 2011 at 4:12 in the
afternoon.

Q. Okay. And when was this authenticated?

A. February the 1st, 2011 at 12:09 p.m.

Q. Okay. What was the preoperative diagnosis?

A. Intrauterine pregnancy at 27 weeks and
five-seventh's days. Prolonged rupture of membranes.
Suspected maternal pulmonary embolism after
percutaneously inserted control (sic) line catheter was
flushed, fetal prolonged deceleration and persistent
fetal tachycardia.

Q. And what was the postoperative diagnosis?

1 A. It was the same.

2 Q. When -- when you say in the preop diagnosis
3 fetal prolonged deceleration, what does that mean?

4 A. That means that the fetal heart rate
5 diminished for greater than two minutes and less than
6 ten minutes.

7 Q. And then you say persistent fetal tachycardia.
8 What does that mean?

9 A. That means that after the recovery, the baby's
10 heart rate was above 160.

11 Q. Okay. Was that something that you felt
12 significant, the persistent fetal tachycardia that led
13 you to put it in the preoperative diagnosis?

14 MR. MITTELMARK: Form.

15 BY MR. SILVA:

16 Q. You can answer.

17 A. There are many reasons why things are included
18 in the preoperative diagnosis. Most of them are because
19 all operations, all C-sections are reviewed at this
20 hospital for appropriateness. So you want to include a
21 sufficient amount of information that would describe the
22 general reasons why the operation was indicated.

23 It's not intended to be all inclusive or all
24 exclusive of all other causes. But it's -- The
25 documentation should support the reason why you're

1 removing a 27 week, five-seventh's date baby out of her
2 mother's womb.

3 Q. In other words, the indication for the
4 procedure?

5 A. Right. And in this case specifically since
6 the baby was so premature you needed to explain in
7 detail the reasons why the baby needed to be delivered.

8 Q. Right. And according to this preoperative
9 diagnosis, this cascade of events requiring this baby to
10 be delivered at this time of gestation started with the
11 central line catheter being flushed.

12 MR PUYA: Form.

13 MS. WIDLANSKY: Join.

14 BY MR. SILVA:

15 Q. Is that your understanding?

16 A. The cascade?

17 Q. Yes.

18 A. Well, yes.

19 Q. Well, the central line was occluded and needed
20 to be flushed with Cathflo. Heather McCants had a
21 reaction to that, which necessitated a phone call to
22 you, you ordering a C-section, and finally the baby
23 being delivered, correct?

24 MS. WIDLANSKY: Form.

25 THE WITNESS: Well, that's one sketch of what

1 happened. The mother's pulse was also twice
2 normal.

3 In other words, we say the highway speed limit
4 is 55, twice -- twice that is 110. The mom's
5 fetal -- the mom's, the mother, Ms. McCants' heart
6 rate was documented in that anesthesia record we
7 just reviewed as an exhibit as being double of what
8 is normal. And --

9 BY MR. SILVA:

10 Q. And that -- I'm sorry. Go ahead.

11 A. And that was another reason why the
12 possibility of a maternal pulmonary embolism or
13 suspected maternal pulmonary embolism was a reasonable
14 working diagnosis in a mother who had a respiratory
15 arrest, who had a rapid response and who a had a
16 persistent fetal heart -- I'm sorry a persistent
17 maternal heart rate that was twice the normal speed.

18 Like I said, if you were a car on the highway,
19 that would be saying like the car was going 110 miles an
20 hour.

21 Q. Sure. And that -- and that persistent
22 maternal tachycardia or a heart rate, all of that
23 occurred after the PICC line was flushed, right?

24 A. Yes.

25 Q. Okay. She didn't have a heart rate that was

1 elevated prior to the PICC line being flushed, did she?

2 A. No. Well, not that high, no.

3 Q. Right.

4 A. She did have a history of having a slightly
5 elevated heart rate on occasions. But that was at a
6 much lower rate of like 110.

7 Q. Sure. And you -- You certainly didn't decide
8 that the baby needed to be delivered because the mother
9 had a heart rate of 110, did you?

10 MS. WIDLANSKY: Form.

11 THE WITNESS: Yes, I did, but not in the
12 operative report. This was in the progress note
13 that I wrote -- and I think we referred to
14 previously. I'm not sure which exhibit it was.

15 BY MR. SILVA:

16 Q. I think you misunderstood my question.

17 A. Oh, okay. My question is you were testifying
18 that prior to this incident the mother's heart rate at
19 some -- at some times would go into the 110 range prior
20 to this incident. Did you elect to perform a C-section
21 based upon the mother's heart rate going to 110 prior to
22 this incident --

23 MS. WIDLANSKY: Form.

24 BY MR. SILVA:

25 Q. -- at any point in time?

1 MS. WIDLANSKY: I'm sorry. Form.

2 Mischaracterization of testimony.

3 BY MR. SILVA:

4 Q. Go ahead.

5 A. No.

6 Q. Okay. When Heather McCants had a heart rate
7 of 110 prior to this incident, did you suspect that she
8 had a pulmonary embolism?

9 MS. WIDLANSKY: Form.

10 THE WITNESS: No. Because she had a previous
11 history of maternal tachycardia.

12 BY MR. SILVA:

13 Q. Okay. And that was documented on the
14 admission to St. Mary's Medical Center, wasn't it?

15 A. I believe it was, yes.

16 Q. So the nurses would or should have known about
17 that?

18 MR. MITTELMARK: Object to the form.

19 THE WITNESS: Yes.

20 BY MR. SILVA:

21 Q. And you knew about it, right?

22 A. Yes.

23 Q. And then the procedure -- What procedure did
24 you dictate in this report?

25 A. A repeat low transverse cesarean section.

1 Q. Okay. Then you have a description of the
2 procedure. And part of your description you say the
3 baby had a prolonged ten minute deceleration.

4 Do you see that about five lines down?

5 A. Yes.

6 Q. And then you say it was followed by
7 tachycardia which was persistent. Do you see that?

8 A. Yes.

9 Q. Why do you qualify the tachycardia as being
10 persistent as opposed to just tachycardia?

11 A. That was my interpretation of the strips at
12 the time that the strips were available for me to
13 review.

14 Q. And when you say persistent, what does that
15 mean?

16 A. That means that again many times in a labor
17 and delivery unit, certainly in antepartum labor and
18 delivery unit, a mother will roll over flat on her back,
19 and the baby may roll over on the umbilical cord, and
20 you'll have a deceleration. Sometimes the decelerations
21 are less than two minutes. Sometimes the decelerations
22 are more than two minutes.

23 After a period of intrauterine resuscitative
24 recovery, which doctors generally think is the best way
25 to handle a deceleration, allow the baby to recover

1 where you have the placenta as the oxygenating unit of
2 exchange as opposed to a premature lung, what will
3 happen is the heart rate will -- the baby's heart rate
4 will go back to a normal range.

5 Sometimes the baby's heart rate does not go
6 back to a normal heart rate. And that's what appeared
7 to be happening here. In addition to all the things
8 that were happening to the mother where the mother had
9 an acceleration of her heart rate to twice normal that
10 persisted throughout the C-section.

11 And in combination with a discussion that I
12 had with an internal medicine hospitalist physician that
13 I had spoken to the procedure to proceed with delivery
14 was not only entertained but in actuality performed.

15 Q. Okay. When did you first speak to that
16 internist?

17 A. Before the patient arrived on the floor -- I
18 mean on the OR unit.

19 Q. Okay. Did that internist influence you in any
20 way in delaying the C-section?

21 A. Delaying?

22 MS. WIDLANSKY: Form.

23 BY MR. SILVA:

24 Q. Yes.

25 A. No.

1 Q. Okay. In your description of the procedure,
2 you state here the patient had her PICC line catheter
3 flushed and immediately developed respiratory arrest for
4 which rapid response was called. Do you see that?

5 A. Yes.

6 Q. Then you go on to say after an adequate level
7 of spinal anesthesia, she was prepped and draped in the
8 usual sterile fashion.

9 What did you mean by an adequate level of
10 spinal anesthesia?

11 A. A level of spinal anesthesia that allowed us
12 to proceed with the surgical procedure.

13 Q. Okay.

14 A. An operation where the patient would not
15 perceive an unacceptable amount of discomfort.

16 Q. Do you know how long it took for
17 Heather McCants to have an adequate level of anesthesia
18 from the time that she was initially given the
19 subarachnoid block?

20 A. Not in minutes and seconds, no.

21 Q. Did you examine Heather McCants to confirm
22 that she had an adequate level of anesthesia prior to
23 performing the C-section?

24 A. Yes. Before I performed the initial incision,
25 I would have done what's called an Allis test where I

1 take a surgical instrument and pinch the area that I
2 intend to make the abdominal incision on. And usually I
3 pinch a few centimeters north of that area as well to
4 make sure that the patient is adequately anesthetized.

5 Q. And you did that at 3:50 or sometime
6 thereafter?

7 A. I don't recall the time, but it was done
8 before the initial incision was made.

9 Q. Okay. But it had to have been at 3:50 or
10 sometime thereafter, because according to the
11 operative -- perioperative note you were not in the room
12 prior to 3:50; do you agree with that?

13 MS. WIDLANSKY: Form.

14 THE WITNESS: Well, again, since I was not the
15 timekeeper, I had other things on my mind, mainly
16 the care and treatment of the mother and the baby.
17 I'd never really tracked the time flow of -- nor
18 did I ever look at my watch or look at a clock to
19 document a specific time that I can recall.

20 BY MR. SILVA:

21 Q. Okay. And as you sit here today, do you have
22 any reason to dispute that time that you first entered
23 the operating room at 3:50?

24 A. Well, you know, clocks in hospitals are
25 interesting things: We have clocks on the wall; we have

1 clocks on the anesthesia machine; people have wrist
2 watches; people have the computer watch. And they're
3 synchronized to whatever level of degree of
4 synchronization that occurred on that specific date and
5 time.

6 Since I'm not the timekeeper, and since I
7 can't -- You know, I -- I've seen cases like this where
8 a nurse will be using the time that's on the electronic
9 medical record panel and not the atomic clock that's on
10 the wall. And then I've seen anesthesiologists use the
11 time on the anesthesia machine or the time on their
12 watch or the time on the atomic clock that's on the
13 wall. So there can be minimal time discrepancies with
14 no malintent. I mean everyone is recording a time.

15 But just like in this room, if we were all to
16 look at our clocks or watches or cell phones or
17 computers, I bet you that they're not all lined up.

18 Q. Okay. And is it possible then that the baby
19 was born at sometime later than 3:52?

20 A. As I mentioned before, my interest was in the
21 care and treatment of the mother and the baby. I was
22 not a timekeeper. I will go by whatever the record
23 indicates as the recorded time and not disagree with it,
24 but I was not the authenticator of the time.

25 Q. Do you know exactly what time this baby was

1 born at?

2 MS. WIDLANSKY: Form.

3 THE WITNESS: No, I do not. Only by -- by
4 what was -- what I was told from other people.

5 BY MR. SILVA:

6 Q. What does that mean?

7 A. Well, like I said, I think one part of the
8 med -- medical record may say that the baby was
9 delivered -- For example, the anesthesia record says
10 1552. I don't have the nurses note from the operating
11 room. But if I were to find it, it may or may not match
12 up exactly. But sometimes it does; sometimes it
13 doesn't.

14 Q. Have you seen the nurses note from the
15 operating room?

16 A. I have in the past. I didn't memorize it. I
17 mean if you want to --

18 Q. You did -- You did in this case?

19 A. I have -- I have seen the electronic operative
20 note that I believe Nurse Braga may have authored in
21 terms of times. In fact, it may be one of the exhibits
22 you handed me. And if you'll give me the exhibits, I'll
23 show you which one.

24 Wasn't one of them the operative -- electronic
25 operative note from Nurse Braga?

1 Q. It might have been on the prior depo, but I
2 don't think we have it today marked.

3 A. I'm sorry.

4 Q. That's okay.

5 A. I thought I had seen it this morning.

6 Q. You can look at other records if you'd like.

7 A. Okay. Let me take a moment.

8 THE WITNESS: Let's go off the record, and let
9 me find it.

10 THE VIDEOGRAPHER: Off the record at 11:23.

11 (A recess was taken.)

12 THE VIDEOGRAPHER: We're now back on the video
13 record at 11:24. This is the beginning of tape
14 two.

15 THE WITNESS: I'm referring to the delivery
16 summary, labor and delivery that appeared to be
17 authored by Nurse Braga. And the times between
18 anesthesia and the delivery summary --

19 Now the anesthesia record, obviously, was
20 recorded by Dr. Lane. And the delivery summary was
21 authored by Josephine Braga, RN. They are
22 coordinate. They match exactly. They say 1552
23 there was delivery. At 1553 there was the removal
24 of the placenta.

25 But not in all cases do the -- do the minutes

1 line up. But not for malintent or not because
2 there is something -- covering something up. It's
3 because people use different time clocks. And the
4 time clocks may or may not be coordinate.

5 BY MR. SILVA:

6 Q. Okay. And according to the medical record in
7 this case, the baby was born at 3:52?

8 A. Both by the delivery summary and by the
9 anesthesia record, correct. But I personally did not
10 record the time of the events.

11 Q. Okay. So as you sit here today, you can't
12 tell me with any reasonable degree of medical certainty
13 according to your recollection of what time this baby
14 was born?

15 A. Correct.

16 Q. Okay.

17 THE WITNESS: Let her in, 3074. I apologize.

18 MR. SILVA: If you need to take it. Go ahead.

19 That's okay.

20 THE WITNESS: That hopefully will have covered
21 it.

22 BY MR. SILVA:

23 Q. I want you to continue looking at your
24 operative note here. And it states two-thirds of the
25 way down on the description of the procedure that cord

1 blood was obtained. Do you see that?

2 A. Yes.

3 Q. What was the cord blood obtained for?

4 A. This cord blood was obtained as a matter of
5 routine so that we can blood type the baby's blood.

6 A very common problem that occurs in
7 pregnancies is that the mother and the baby do not have
8 the exact blood type. And it cause the baby to turn
9 yellow or jaundice. And there's a blood/blood reaction
10 between the mother's and baby's blood.

11 So what I did was I opened up the clamp of the
12 umbilical cord and obtained a sample of blood to be
13 submitted to the laboratory for evaluation of the baby's
14 blood type.

15 Q. Okay. Did you order a cord blood gas?

16 A. I did not order a cord blood gas because it
17 was not medically indicated.

18 Q. That was according to your judgment, right?

19 MS. WIDLANSKY: Form. Asked and answered.

20 THE WITNESS: Well, no, not only is it to my
21 judgment. But, yes, my judgment indicated that the
22 baby was vigorous with an Apgar of eight at one
23 minute and an Apgar of eight at five minutes. And
24 Dr. Ambroise I believe was the assignor of the
25 Apgar scores as a -- as she was the neonatologist

1 in attendance at this high-risk delivery.

2 If doctor -- If there was an issue about the
3 baby's oxygenation or acid base status,
4 Dr. Ambroise had the ability to order a blood gas
5 immediately that would have been much more accurate
6 than an umbilical cord gas.

7 There is no policy at St. Mary's, nor is there
8 a national policy that indicated that this baby on
9 this case needed to have a cord blood -- cord blood
10 gas obtained.

11 BY MR. SILVA:

12 Q. Do you know what the baby's cord blood gas
13 would have been if the baby was born five minutes prior
14 to 3:52?

15 A. No.

16 Q. Do you know what the Apgar scores would have
17 been if this baby was born five minutes prior to 3:52?

18 MS. WIDLANSKY: Form.

19 THE WITNESS: No.

20 BY MR. SILVA:

21 Q. So that would be at 3:47.

22 Do you know what the Apgars would have been at
23 3:42, if this baby had been born at 3:42?

24 A. No.

25 MS. WIDLANSKY: Form.

1 BY MR. SILVA:

2 Q. Do you know what the Apgars would have been at
3 3:37 if this baby had been born at 3:37?

4 MS. WIDLANSKY: Form.

5 THE WITNESS: No.

6 BY MR. SILVA:

7 Q. Do you know what the Apgars would have been at
8 3:32 if the baby had been born at 3:32?

9 MS. WIDLANSKY: Form.

10 THE WITNESS: No.

11 BY MR. SILVA:

12 Q. Do you know what the Apgars would have been at
13 3:27 if the baby had been born at that time?

14 MS. WIDLANSKY: Form.

15 MR. BLOOM: Join.

16 THE WITNESS: Respectfully, no.

17 BY MR. SILVA:

18 Q. Okay. And same question for cord blood gases
19 if they had been ordered back any of those times, do you
20 know as you sit here today what those cord blood gases
21 would have been?

22 MS. WIDLANSKY: Form.

23 THE WITNESS: No.

24 MR. BLOOM: Join.

25 THE WITNESS: Okay. Let me go off the

1 record --

2 MR. SILVA: Go ahead.

3 THE WITNESS: -- for one tiny second.

4 THE VIDEOGRAPHER: Off the record 11:28.

5 (A recess was taken.)

6 THE VIDEOGRAPHER: Back on the record at

7 11:29.

8 BY MR. SILVA:

9 Q. Let's see. We are up to -- That's 21?

10 A. Yes, sir.

11 Q. Thank you.

12 MR. SILVA: I'm going to mark this document as
13 Plaintiff's Exhibit Number 22.

14 (Plaintiff's Exhibit Number 22 was marked for
15 identification.)

16 BY MR. SILVA:

17 Q. This is Dr. Jumapao's consultation note. Is
18 this the doctor that you spoke with --

19 A. Yes.

20 Q. -- regarding Heather McCants' condition?

21 A. Yes, sir.

22 Q. Okay. And according to this document, there's
23 a history there. And can you read that history into the
24 record?

25 A. This 24-year-old white female with a known

1 history of sinus tachycardia as well as history of
2 preeclampsia from the second pregnancy. Patient
3 apparently was transferred from Indian River Hospital
4 last January the 12th for a premature rupture of
5 membranes. She has been here for a quite a while, and
6 today she was noted to have a flattened PICC line and
7 was given Cathflo, which patient immediately was
8 complaining of shortness of breath, getting cyanotic,
9 hypoxemic, desaturated and immediately had an emergent
10 C-section. Apparently, the fetal heart rate also
11 desaturated.

12 Q. Okay. Do you know where Dr. Jumapao got this
13 information?

14 A. No.

15 Q. Do you know if Dr. Jumapao ever examined
16 Heather McCants prior to the C-section?

17 A. I don't believe she did.

18 Q. Okay. And according to this consult note,
19 what time was it dictated at?

20 A. 1659.

21 Q. That's 4:59?

22 A. Yes.

23 Q. Did you -- did you talk to Dr. Jumapao in the
24 postop recovery area?

25 A. I did. But I also spoke to her before

1 Heather McCants arrived.

2 Q. Okay. And that conversation that you had with
3 Dr. Jumapao prior to the surgery, did either you or
4 Dr. Jumapao conclude that you needed to perform any
5 additional tests to investigate this possible pulmonary
6 embolism that delayed the delivery of the baby?

7 A. Well, I don't know that anything delayed the
8 delivery of the baby. So could you rephrase your
9 question.

10 Q. No, I'm not going to rephrase. I'm going
11 to --

12 A. Okay. Could you repeat the question again?

13 Q. Yeah. I'm going to ask her to repeat it back
14 to you so you can answer it.

15 A. Okay.

16 (The question was read by the reporter.)

17 MR. MITTELMARK: Form.

18 MS. WIDLANSKY: Form.

19 MR. PUYA: Join.

20 THE WITNESS: I don't understand your
21 question, because no testing was performed. And
22 there was no delay in performing the cesarean
23 section.

24 BY MR. SILVA:

25 Q. Okay.

1 A. So if you could -- If you choose to rephrase
2 it, it's up to you. Otherwise I'm just going to simply
3 say that factually there was no delay in delivery of
4 this baby. And there -- there was no discussion of a
5 test that could have in theory or an evaluation needed
6 to have been performed in theory that would have caused
7 a delay.

8 Q. Okay. So I want to be clear about this. You
9 didn't discuss any tests with Dr. Jumapao that needed to
10 be performed or were performed prior to the C-section,
11 correct?

12 MR PUYA: Form.

13 MS. WIDLANSKY: Form.

14 MR. BLOOM: Join.

15 THE WITNESS: To the best of my recollection
16 that's correct.

17 BY MR. SILVA:

18 Q. Okay. Did -- did -- Was there a spiral CT
19 performed prior to the procedure?

20 A. No.

21 Q. Was there a VQ scan performed prior to the
22 procedure?

23 A. No.

24 Q. Was there any blood work such as a D-dimer
25 performed prior to the procedure?

1 A. No.

2 Q. So the entire pulmonary embolism workup was
3 performed after this procedure, correct?

4 A. Yes.

5 Q. I'm going to have you take a look at what we
6 marked earlier as Plaintiff's Exhibit Number 14, which
7 is the timestamp for you coming into the hospital.

8 Prior to you arriving on the L&D floor at
9 3:33, was Heather Mc -- was Heather McCants in the preop
10 holding area when you arrived there at 3:33?

11 A. No.

12 Q. And is that the reason that you left the OB
13 operative area to determine where she was?

14 A. Yes. And where they were in the process of
15 getting her ready for a C-section.

16 Q. Did you call back to the antenatal unit, or
17 did you just decide that you were going to walk up there
18 and see what -- what the delay was?

19 A. Both.

20 Q. So did you call first?

21 A. Yes.

22 Q. And you spoke -- Who did you speak with?

23 A. I don't know that I independently recall with
24 exactitude who I spoke to. I may have spoken to one
25 person who received the phone call and then may have

1 transferred the phone call to another person. That's
2 what I recall.

3 Q. Did you make the phone call before you left
4 the OB operative area to go back -- back up to the
5 floor?

6 A. Yes.

7 Q. Okay. And after you made the phone call, why
8 did you decide to go back to the -- to the prenatal
9 area?

10 A. Because when the elevator door opened, Laurie,
11 the director of labor and delivery unit, walked out and
12 said she was being -- Ms. McCants was being transported
13 and was on her way.

14 Q. Right. But my question is after you got off
15 the phone with the antenatal unit, you still decided to
16 leave the OB operative area and go back to the elevator
17 bank, and you were going up to Heather McCants' floor.
18 Why did you do that?

19 A. In the event that there was something I could
20 do to facilitate the movement of Ms. McCants. I knew
21 Ms. McCants. Ms. McCants is a wonderful person. She
22 does have some medical situations that are unique to
23 her. She was 350 pounds. A 350-pound patient sometimes
24 have to be rollered or may have to be facilitated in
25 their movement, and I'm obviously a large person. And

1 the nurses -- I know Nurse Duckworth is not that big.
2 Okay?

3 And depending on if there was a -- if there
4 were reasons that I could facilitate the transfer of
5 Ms. McCants more timely, my intent was to go on the
6 floor and facilitate.

7 Now, there is also the possibility that since
8 I didn't know moment by moment exactly where they were
9 in the process, if there was something that I could do
10 to facilitate her movement towards the OB/OR, I thought
11 that by physically going up there and seeing personally
12 what's going on that it would resolve my own anxiety and
13 may facilitate the transfer as I said.

14 Q. Would you expect Janis Duckworth, her
15 attending nurse, to ask for help if she had any trouble
16 transporting her to the operating room?

17 A. Yes.

18 Q. Do you know how many other nurses and
19 available staff were around Heather McCants when it was
20 decided that she needed to be transported to the
21 operating room?

22 A. I didn't know exactly. But as I said, when
23 the elevator doors opened and I was in front of the
24 elevator bank and Laurie came out, I was told that they
25 had adequate help and she was on her way.

1 Q. Okay. And when -- when was the first time
2 that you set eyes on Heather McCants?

3 A. When she rolled into the area outside the
4 operating rooms on the OB floor, on the first floor.

5 Q. Okay. So after you spoke with Laurie Matich,
6 you went back to the operating room area. And that's
7 when you entered that area again at 3:37?

8 A. Yes.

9 Q. Okay. And how long were you there waiting for
10 Heather McCants before you first laid eyes on her?

11 A. I don't know. Again, I never -- I never
12 became a timekeeper. I was more concerned to ensure the
13 safety of Ms. McCants and her baby.

14 Q. Well, when you went back at 3:37, she was not
15 in the OB operating area, right?

16 A. That's correct.

17 Q. Okay. So at some point in time after the time
18 that you entered the OB operating area the second time,
19 which was 3:37 and four seconds p.m., at some point in
20 time thereafter Heather McCants arrived to the OB
21 operating room area, right?

22 A. Yes.

23 Q. And then still at that time she had to be
24 evaluated by anesthesia?

25 A. Correct.

1 Q. And she had to have her anesthetic given,
2 whether it was general anesthesia or subarachnoid block
3 or an epidural?

4 A. Correct.

5 Q. She had to obtain adequate anesthesia before
6 you could perform the procedure, right?

7 A. Correct.

8 Q. And do you know what your involvement was from
9 3:37 until 3:50 in regards to making Heather McCants'
10 C-section occur as quickly as possible?

11 A. Yes. What I did was I contacted the
12 hospitalist Dr. - I don't know if I'm massacring this
13 name --

14 Q. Jumapoa?

15 A. -- Jumapoa. And I had moved some carts that
16 were in the way prior to Ms. McCants' arrival to the
17 operating room area, the preop operating room area.

18 So in other words, I tried to clear a clear
19 path so that when she arrived she could be moved into
20 the room as timely as reasonably possible.

21 Q. Okay. When you went back into the OB
22 operative area at approximately 3:37, was there an
23 operating room staff assembled to perform this
24 C-section?

25 A. I believe that there was an operating room

1 staff available, yes.

2 Q. Had they -- Were they performing another
3 procedure?

4 A. When I initially presented to the OB preop
5 area and poked my head into an operating room where they
6 were concluding another cesarean section, but it seems
7 to me that at St. Mary's there are resources for more
8 than one C-section in terms of nursing staff, in terms
9 of anesthesiologists that are available.

10 Q. From the time that you first got to the labor
11 and delivery area at 3:33, do you know if any of the
12 nurses requested that Dr. Sanches start the C-section
13 prior to your arrival?

14 MR. BLOOM: Form.

15 MS. WIDLANSKY: Form.

16 THE WITNESS: I have no knowledge of anything
17 that happened before my arrival.

18 BY MR. SILVA:

19 Q. Okay. So you have no knowledge prior to 3:33
20 of what occurred in the antenatal unit with regards to
21 preparing Heather McCants to be brought down to the
22 operating room, right?

23 A. Other than what I was told by I believe it was
24 Nurse Duckworth, correct.

25 Q. And you have no knowledge of what time the

1 Rapid Response Team was called?

2 A. At that time, no. Subsequently when I saw the
3 medical records in preparation for this series of
4 depositions and probably when -- immediately after when
5 the chart became available to me in the preop area, yes.

6 Q. Prior to 3:33, did you instruct Lisa Sanches,
7 M.D., to start the C-section?

8 A. I did not speak with Lisa Sanches. And,
9 therefore, I did not instruct or not instruct
10 Lisa Sanches, Dr. Lisa Sanches as to what she should do.

11 Q. Did prior to 3:33 Lisa Sanches, M.D., the OB,
12 24-hour OB that day, did she contact you and volunteer
13 to start the C-section prior to your arrival?

14 A. I believe I've already mentioned that
15 Dr. Sanches and I had no communications before or
16 subsequent in regards to the McCants' case.

17 Q. Do you have a private practice office on the
18 campus of St. Mary's Medical Center?

19 MR. MITTELMARK: Object to the form.

20 THE WITNESS: No.

21 BY MR. SILVA:

22 Q. Okay. Do you know if the 24-hour OB group has
23 a private practice office on the campus of St. Mary's
24 Medical Center?

25 MR. MITTELMARK: Object to the form.

1 THE WITNESS: They have one on the campus,
2 yes.

3 BY MR. SILVA:

4 Q. They do, right?

5 A. Yes.

6 Q. And what -- what is your understanding of
7 where that building is in relation to the hospital?

8 MR. MITTELMARK: Object to the form.

9 THE WITNESS: It's -- You have to cross the
10 west parking lot, west doctors' parking lot to
11 enter the actual physical property of the hospital.

12 BY MR. SILVA:

13 Q. Okay. And does the front area of the hospital
14 get closed off at a certain time at night? There is
15 like a guard gate there.

16 A. Yes. They -- they -- they have gates in the
17 perimeter that are generally closed either at -- after
18 11:30 or somewhere around midnight.

19 Q. Okay.

20 A. And access is restricted to the eastern
21 entrance.

22 Q. That's the Greenwood entrance?

23 A. Yes. The Greenwood Avenue entrance, yes, sir.

24 Q. Okay. And if the guard gate is closed at
25 night, the only way to access the physicians' office for

1 OB -- OB/GYN Specialists is also there through the
2 Greenwood area?

3 A. Correct.

4 MR. BLOOM: Form.

5 BY MR. SILVA:

6 Q. Okay. There is no other way to access that
7 office space after 11:00 or 12:00 at night, correct?

8 A. Correct.

9 Q. Because this property is -- I think it's
10 fenced or gated?

11 A. It's -- it's fenced. They have an ironworks
12 fence that runs the perimeter of the property.

13 Q. Do you know if Dr. Lane ever called
14 Dr. Sanches and requested that she start the C-section
15 prior to your arrival?

16 A. I have no knowledge of what Dr. Lane did.

17 Q. Do you know if the nurses went up the chain of
18 command to try to get an OB to perform the C-section
19 prior to your arrival at 3:33?

20 MR. MITTELMARK: Object to the form.

21 THE WITNESS: I don't know.

22 BY MR. SILVA:

23 Q. When you order -- When a physician orders a
24 C-section or any surgical procedure, an OB/GYN at
25 St. Mary's Medical Center, do you know if it's a

1 requirement for the nurses to enter that physician's
2 order into the chart?

3 A. I don't know procedurally whether that's the
4 case or not.

5 Q. Do you know if the nurses wrote a telephone
6 order for a C-section -- for the C-section that you
7 ordered?

8 A. I don't know. I could look at the records
9 with -- with that in mind.

10 Q. Did you ever see any telephone order for a
11 C-section by the nurses in this case?

12 A. Not to my recollection, no.

13 Q. When you normally call in an order by
14 telephone where the nurse writes down your instructions
15 under the physician's orders, do you expect the nurse to
16 time and date that order?

17 MR. MITTELMARK: Object to the form.

18 THE WITNESS: Well, in general, yes. But
19 there are some circumstances where I think care of
20 the patient takes precedence over documentation.

21 And documentation -- You know, sometimes
22 things happen very acutely in obstetrics. And I
23 think reasonable people would not want the nurses
24 to stop caring for the people that they are caring
25 for and write extensive, sophisticated notes, but

1 would prefer that the medical needs of the patient
2 be addressed first and then documentation can occur
3 at a later time.

4 BY MR. SILVA:

5 Q. You're talking about emergency situations,
6 right?

7 MS. WIDLANSKY: Form.

8 THE WITNESS: We're talking about --

9 MR PUYA: Join.

10 THE WITNESS: There's a -- there's a range of
11 events. If we're talking about an event that's
12 evolving that requires the full attention of the
13 nurse to stabilize or preserve life and care for a
14 patient, I would not want that nurse to be
15 documenting. I would want that nurse to do those
16 things that a nurse should do by her actions, and
17 then the documentation can come later on.

18 BY MR. SILVA:

19 Q. Do you know how many nurses were available to
20 write a physician's telephone order at the time that you
21 ordered the C-section?

22 MR. MITTELMARK: Object to the form.

23 THE WITNESS: I don't know the number of
24 nurses that were available. But if you -- It
25 always seems that, again, if we're talking about an

1 emergency, I think all the nurses respond to being
2 available to do those things they need to do or
3 want to do or can do to make the situation as good
4 as it can be in an emergency situation.

5 We understand documentation is important. But
6 documentation is not number one when patients'
7 lives are at stake or there may be a concern that a
8 patient may deteriorate to an emergency situation
9 that can get out of hand.

10 BY MR. SILVA:

11 Q. The most important thing, you would agree, is
12 to take care of the patient as quickly as possible to
13 avert a bad outcome for the patient or the baby, right?

14 A. Yes.

15 Q. Did you ever conclude that Heather McCants had
16 an allergy to Cathflo?

17 A. No. I did not make a -- I did not make the
18 determination of her relationship with Cathflo.

19 Q. Okay. I'm going to hand you what I'm marking
20 as Plaintiff's Exhibit Number 3 (sic), which is a
21 physician's order timed at 7:35 and dated 1/26.

22 (Plaintiff's Exhibit Number 23 was marked for
23 identification.)

24 BY MR. SILVA:

25 Q. Is that your handwriting?

1 A. No, it is not.

2 Q. Do you know if that's Dr. Jumapao's
3 handwriting?

4 A. I don't know that -- what her handwriting
5 looks like. But I can see that at -- It seems like the
6 first letter is a J, and it ends with P-O-A.

7 Q. Okay. Okay.

8 A. But I also see there is a slash and another
9 signature. So I cannot speak to the author of the
10 notation that you're referring to as allergy to Cathflo.

11 But her name is it looks to me like -- I would
12 have to say as a doctor reading doctors' handwritings
13 that Jumapoa slash P-A-P-H and then scribble.

14 Q. Okay. And what is entered into that
15 physician's order?

16 A. Allergy to Cathflo.

17 Q. Do you know how Dr. Jumapao concluded that
18 Heather McCants had an allergy to Cathflo?

19 MR. MITTELMARK: Object to the form.

20 MS. WIDLANSKY: Form.

21 MR. BLOOM: Join.

22 THE WITNESS: Well, I'm not sure that that
23 determination was made conclusively.

24 I think, you know, from my interpretation of
25 Dr. Jumapoa's notes in an abundance of precaution

1 she wanted to restrict the contact of Cathflo and
2 Mrs. McCants.

3 And allergy -- You know an allergy to me means
4 something perhaps very specific, and to other
5 people it may not be as specific. An allergic
6 reaction to me is a histamine mediated response,
7 which I don't believe was the case in the
8 descriptor of what happened when Ms. McCants had
9 her PICC line flushed with Cathflo.

10 BY MR. SILVA:

11 Q. Did you disagree with that statement: Allergy
12 to Cathflo?

13 A. Again --

14 MR. MITTELMARK: Object to the form.

15 MS. WIDLANSKY: Join.

16 THE WITNESS: Again, in doctor talk as I was
17 trained, allergy means one thing. There are many
18 substances that people come in contact with that
19 have disagreeable reactions to.

20 For example, some patients say that, well, you
21 know, I'm allergic to Percocet; it makes me
22 nauseous.

23 Well, that -- that's really a side effect and
24 not a true allergy.

25 There are other patients who say, I'm allergic

1 to Percocet, but since I'm having surgery, that's
2 what I want, and I'll deal with the side effect.

3 I think in an abundance of caution, my
4 interpretation what Dr. Jumapao's name appears on
5 this order is in an abundance of precaution to
6 alert all the members of the health care team that
7 this order be entered so that Ms. McCants and
8 Cathflo did not become friendly again.

9 BY MR. SILVA:

10 Q. Did you ever have any discussions with
11 Dr. Jumapao about that entry: Allergy to Cathflo?

12 A. No.

13 Q. And at the top of this form it says allergy,
14 and it has Cathflo next to it?

15 A. Yes.

16 Q. Do you know if any policy or procedure exists
17 at this hospital, St. Lucie -- or St. Mary's Medical
18 Center for the maintenance of PICC lines?

19 A. I have seen a policy and procedure for
20 maintenance in the past, yes.

21 Q. When you left this facility at 4:15, do you
22 recall where you went?

23 MS. WIDLANSKY: Form.

24 THE WITNESS: No.

25 MR. SILVA: Okay. All right. Thank you for

1 your time.

2 THE WITNESS: Yes, sir.

3 MR. MITTELMARK: I'm going to have questions.

4 MR. PUYA: Go ahead.

5 MR. MITTELMARK: Okay. Dr. Lopez --
6 Dr. Lopez, do you need a break, because I'm going
7 to have some questions for you?

8 THE WITNESS: No, I'm -- I'm fine.

9 MR. MITTELMARK: Great.

10 CROSS-EXAMINATION

11 BY MR. MITTELMARK:

12 Q. Dr. Lopez, I introduced myself to you before.
13 I'm Mike Mittelmark. I represent St. Mary's Medical
14 Center. I know you covered a lot of ground about
15 January 26, 2011, but I want to take you back to when
16 Ms. McCants was -- or Mrs. Shelton now, but Ms. McCants
17 at the time, was admitted to St. Mary's Medical Center.

18 And what I would like to do is I know you
19 covered this in your first deposition, but just tell me
20 in 2011, January 2011, who was your employer?

21 A. I was employed by Berto Lopez, M.D., P.A.

22 Q. Were there any other employees of that
23 professional association in January of 2011?

24 A. Yes. I had between 11 and 13 employees in
25 addition to myself.

1 Q. And what physicians were employed with Berto
2 Lopez, M.D., P.A., in January of 2011?

3 A. I was the only physician employed.

4 Q. Okay. So in January of 2011 who paid your
5 salary?

6 A. Berto Lopez, M.D., P.A.

7 Q. Who controlled your vacation schedule?

8 A. Berto Lopez, M.D., P.A.

9 Q. Who controlled your on-call schedule?

10 A. Berto Lopez, M.D., P.A.

11 Q. Who paid taxes for you?

12 A. I'm not -- Probably Berto Lopez M.D., P.A.,
13 paid part of the taxes.

14 Q. I gotcha. I gotcha. Did you get a W-2 form
15 from Berto Lopez, M.D., P.A.?

16 A. I believe I did, yes.

17 Q. And health insurance, who paid for that?

18 A. Berto Lopez, M.D., P.A.

19 Q. Okay. So do you recall back in January of
20 2011 how it was that you first became involved with
21 Heather McCants as a patient?

22 A. Yes. The perinatologist, Dr. Stoessel,
23 contacted me and asked if I would be willing to take a
24 high-risk obstetrical patient as a transfer patient from
25 Indian River Medical Center who had ruptured her

1 membranes prematurely.

2 Q. And tell us a little bit about Dr. Stoessel.
3 Who is that?

4 A. Dr. Stoessel is a perinatologist. That means
5 on OB/GYN who specializes in high-risk pregnancies. And
6 he was involved in a perinatal transfer unit that was
7 independent of St. Mary's hospital. And for a long time
8 we accepted perinatal transfers from about a ten county
9 service area.

10 Q. All right. You take all comers, don't you?

11 A. We take all comers. And for -- for hospitals
12 that do not have that level of care available for their
13 high-risk patients. In other words, St. Mary's has a
14 Level 3 nursery, has a pediatric hospital, has many
15 pediatric subspecialists, a pediatric open heart
16 surgeon, which is unique in Florida. One -- You know,
17 one of the few centers that has all of these services
18 available.

19 And for a number of years, in fact, from the
20 beginning of my career at St. Mary's, I've been involved
21 in one way or another with accepting patients
22 independent of the hospital that they were coming from
23 or independent of all other characteristics, but because
24 of their high-risk nature to bring them to a facility
25 that could provide the appropriate care for the patient

1 and their unborn babies.

2 Q. And in this case that facility was St. Mary's
3 Medical Center?

4 A. Correct.

5 Q. And you would agree that prior to Ms. McCants
6 being admitted to St. Mary's Medical Center I believe on
7 January 12, 2011, you had never met her before?

8 A. Correct.

9 Q. So what I have in front of me, and if your
10 counsel has a copy, otherwise I'll provide you my copy,
11 is an OB history, physical and admit note. And I'd like
12 you to take a look at that.

13 MR. MITTELMARK: And we're going to go ahead
14 and mark that as the next exhibit.

15 MR. SILVA: You mean Defense -- Defense 1?

16 MR. MITTELMARK: Okay. Defense 1. That's
17 fine.

18 (Defendant's Exhibit Number 1 was marked for
19 identification.)

20 BY MR. MITTELMARK:

21 Q. Dr. Lopez, what is that document that you're
22 looking at?

23 A. That is an obstetrical history, physical and
24 admit note that was completed by me on January 12th of
25 2011.

1 Q. And can you just briefly describe what it is
2 that you did and how it was that you came to write on
3 such a document?

4 A. As part of the medical record obligation, this
5 is an instrument that details why Ms. McCants was
6 hospitalized and needed the services of hospitalization,
7 and specifically indicated her past history of having
8 prenatal care by Dr. Zoffer and having had premature
9 rupture of membranes, two previous cesarean sections and
10 having abnormal prenatal labs, which included a positive
11 alpha-fetoprotein test which made this a very high-risk
12 pregnancy at 25 weeks of gestation.

13 Q. And that's your signature, right?

14 A. Yes.

15 Q. And you dated it, correct?

16 A. Yes.

17 Q. And you obtained this information from
18 speaking to Ms. McCants?

19 A. Correct.

20 Q. So as of January 12, 2011, you were aware of
21 Ms. McCants and her prenatal history and the reason for
22 her admission, right?

23 A. Yes.

24 Q. Okay. So the next thing I have is a
25 consultation report dated January 13, 2011.

1 MR. MITTELMARK: We'll go ahead and mark that
2 as a Defense Exhibit Number 2.

3 (Defendant's Exhibit Number 2 was marked for
4 identification.)

5 BY MR. MITTELMARK:

6 Q. And I just need you to identify what that
7 document is.

8 A. This is a document dictated by Dr. Ruel
9 Stoessel, the high-risk perinatologist, as a
10 consultation that was performed on January the 13th,
11 2011 on Ms. McCants.

12 Q. And what history did Dr. Stoessel dictate
13 based on his -- your review of his consultation?

14 A. This is a patient who was transferred from
15 Indian River Memorial Hospital because she had preterm,
16 premature rupture of membranes, which occurred on
17 January the 12th at 10:30 in the morning.

18 He details the high-risk factors that included
19 the preterm rupture of membranes. She also -- He also
20 details that she had failed her glucose screen at 145,
21 but had passed her three hour glucose test. She was
22 known to have an elevated white count at Indian River
23 Medical Center of 30,000, which is abnormal, and a
24 positive shift to left, which was potentially suspicious
25 for infection.

1 Furthermore, this patient was approximately 26
2 weeks pregnant and had an estimated fetal weight of one
3 pound, fourteen ounces. The amniotic fluid index was
4 7.5, which was -- appeared to be clinically stable,
5 meaning it wasn't going up or down.

6 There were no overt signs of infection. But
7 in abundance of precaution, antibiotics were prescribed.
8 And the patient was to be monitored for temperature,
9 white count, evidence of a foul discharge, contractions,
10 fetal heart rate that's high and mother's heart rate
11 that is high. And that she needed periodic high-risk
12 monitoring. And that she needed to have a C-section
13 since she's had a prior C-section.

14 But the goal was to give her baby a chance to
15 grow as large as possible and to monitor the mother to
16 make sure she was safe and within normal parameters.

17 Q. Okay. You would agree that that was your goal
18 as well, right?

19 A. Yes.

20 Q. And you and Dr. Stoessel were taking care of
21 Heather McCants as of January 12, 2011?

22 A. Correct.

23 Q. And Dr. Stoessel dictated in his consultation
24 note that he discussed the risk of infection with
25 Ms. McCants.

1 As a board certified OB/GYN physician, can you
2 tell us what the risk of infection would be for a
3 patient such as Heather McCants?

4 MR. SILVA: Object to the form.

5 THE WITNESS: As to the mother, the risk of
6 infection would include the uterus could be
7 infected because one of the barriers that normally
8 is present was absent with the rupture of the
9 membranes.

10 Additionally, the baby was at risk of an
11 infection. And this is -- this is a problem
12 because if a baby gets an infection, it could harm
13 the brain, it could harm the heart and the lungs
14 and the kidneys. They could place the baby's life
15 in jeopardy. Infection is a very serious thing.
16 Especially in a baby this small, one pound and
17 fourteen ounces by estimation.

18 BY MR. MITTELMARK:

19 Q. So this is what you would consider as a board
20 certified OB/GYN physician as a high-risk patient?

21 MR. SILVA: Object to the form.

22 THE WITNESS: Oh, yes. This patient is high
23 risk for many reasons. The water broke when the
24 mother was less than 27 weeks. The baby was at
25 risk of infection and prematurity and premature

1 delivery.

2 Now, prematurity when you're talking about a
3 one pound, fourteen ounce baby, you're talking
4 about a baby whose brain isn't developed yet. The
5 blood vessels, the arteries and the veins aren't
6 ready to come out. The digestive tract isn't ready
7 to come out. The lungs aren't ready to come out.
8 Come out -- What I mean by come out, I mean come
9 out into the world where we as adults and as -- as
10 full-term babies have come out with our brains, our
11 lungs, our digestive tracts ready to go.

12 And babies' brains generally don't deliver
13 till -- I mean don't fully mature until six months
14 after a full-term baby is delivered, let alone a
15 baby that's 13 weeks premature.

16 So this baby was at a tremendous risk of not
17 being whole, not having all the things that a
18 full-term baby would have.

19 Furthermore, during the testing of
20 Ms. McCants' pregnancy, we found out that she had a
21 couple of abnormalities. She had a positive
22 alpha-fetoprotein test, which is a protein test
23 that indicates that something bad might happen to
24 this baby or maybe this baby is not quite right.

25 And she had had to have a special test called

1 level 2 ultrasound, which is a very detailed
2 ultrasound to -- to look for any sort of
3 abnormalities.

4 She failed her sugar screen, but passed her --
5 her three hour glucose test.

6 Now, this baby is very different than the two
7 other children she had. She had one child that was
8 eight pounds, six ounces. And she had another baby
9 that was seven pounds. Both of them delivered by
10 C-sections where she had other problems that made
11 her high risk.

12 So she was in the scope of high-risk patients
13 in the highest level of high risk that high risk
14 consists.

15 BY MR. MITTELMARK:

16 Q. And you as a board certified OB/GYN physician
17 have been caring for these types of patients with these
18 types of high-risk conditions your entire career, true?

19 A. Correct. With the benefit of a perinatologist
20 like Dr. Stoessel and a hospital and a team of nurses
21 and doctors that can help and support the babies once
22 they are born, yes.

23 Q. Okay. What I'm going to show you next is your
24 progress note for January 13, 2011. I just need you to
25 take a look at it, verify that it is your progress note.

1 And I'd like you to read it into the record.

2 MR. MITTELMARK: And if I didn't say it, mark
3 as the next Defendant's exhibit. I think we are at
4 Three.

5 (Defendant's Exhibit Number 3 was marked for
6 identification.)

7 THE WITNESS: The note is dated January 13,
8 2011. No contractions. Afebrile. Vital signs
9 stable. The fetal heart rate was recorded as 145.
10 The estimated fetal weight was one pound, fourteen
11 ounces. And the baby was head down, vertex. The
12 amniotic fluid index was 7.5.

13 My assessment was intrauterine pregnancy at 25
14 weeks. Preterm rupture of membranes. Positive
15 AFP, which is alpha-fetoprotein test. Previous
16 cesarean section times two. Continue with the
17 steroid series, and I ordered and obtained a NICU
18 consult.

19 BY MR. MITTELMARK:

20 Q. Okay. And why did you order the NICU consult?

21 A. Because -- Several reasons. First of all, the
22 NICU at St. Mary's is a special NICU. It's a Level 3
23 NICU. It takes care of the earliest of the earliest.
24 And these are babies that many times they're quite sick.

25 Again, Ms. McCants had two previous full-term

1 babies. She had no previous premature babies.

2 So part of the reason I ordered the consult
3 was for her education of the risk of the baby she was
4 presently carrying.

5 The NICU consult usually entailed a
6 neonatologist, which is a pediatrician with special
7 training of dealing with high-risk babies coming to the
8 bedside and assessing the patient in a timely way,
9 explaining to the patient the things that might be
10 expected if certain things might happen.

11 For example, if the baby were born premature,
12 the brain, the lungs, and the digestive tract are
13 nowhere near ready. If the membranes have been ruptured
14 for a long time, this baby may need to be put on
15 antibiotics for a while. This baby may have to have
16 help breathing and may have to have a tube put down its
17 throat.

18 They basically go over all the things that
19 might happen for a baby that's going to be potentially
20 born prematurely. And the goal of that is both to
21 prepare the patients mentally and to educate them as to
22 what may happen, and -- and to try to decrease the risk
23 of surprise and also to be -- initiate that engagement
24 of the patient in the care of their -- of their babe
25 before it comes out.

1 Q. Okay. So now let me stop you. You're
2 admitting this patient on January 12th. You get
3 Dr. Stoessel involved as a perinatologist on
4 January 13th. And you're also seeing Heather McCants as
5 a patient because you're drafting a progress note on
6 January 13th, correct?

7 A. Yes.

8 Q. And then you ask for a NICU consult. So you
9 want another specialist to get involved in the care and
10 treatment of Ms. McCants and her unborn fetus?

11 A. Correct.

12 Q. And I want to show you a prenatal consult
13 note. And it's I believe signed by Jade Sha, S-H-A,
14 M.D. I'm going to ask you to take a look at that and
15 tell me do you know who Dr. Sha is?

16 A. Yes. Dr. Sha is one of the neonatologist, the
17 pediatricians with special high-risk training, that work
18 at St. Mary's hospital.

19 MR. MITTELMARK: And we'll go ahead and mark
20 that as the next Defendant's exhibit.

21 (Defendant's Exhibit Number 4 was marked for
22 identification.)

23 BY MR. MITTELMARK:

24 Q. So now we have you, the board certified
25 OB/GYN, we have the perinatologist, and we have the

1 neonatologist all involved in the care and treatment of
2 Heather McCants as of January 14, 2011?

3 A. Yes.

4 Q. And I have another progress note from you
5 that's dated January 14, 2011. I will just ask that you
6 read that into the record.

7 MR. MITTELMARK: And we're going to mark that
8 as Defendant's Exhibit Number Five.

9 (Defendant's Exhibit Number 5 was marked for
10 identification.)

11 THE WITNESS: On January 14th --

12 MR. MITTELMARK: Or Six. I'm sorry. I'm
13 losing track.

14 THE WITNESS: -- 2011 she denies contractions.
15 Her amniotic fluid index is 7.5 today with a
16 biophysical profile that is 8 out of 8. She was
17 positive beta strep by the cultures that we did
18 when she was admitted. She did not -- She was
19 afebrile. Her vital signs were stable. Her
20 abdomen was soft, non-tender and there was fetal
21 heart activity.

22 She was assessed as a intrauterine pregnancy
23 at 26 weeks, 1 day with preterm rupture of
24 membranes, positive beta strep.

25 My plan was for her to continue IV

1 antibiotics. And the NICU consult I saw had been
2 completed. And then I signed it.

3 BY MR. MITTELMARK:

4 Q. Okay. I have another progress note that's
5 dated January 14, 2011. And I think it says MFM at the
6 top. Would you know what that stands for?

7 A. Maternal fetal medicine.

8 Q. Right. And it's authenticated by Aaron
9 Deutsch. Do you know who that is?

10 A. Yes. He is also a high-risk perinatologist, a
11 OB/GYN who has special training in high-risk
12 pregnancies, who was part of the Dr. Stoessel group.

13 Q. I have another progress note which I think was
14 signed by you on January 18, 2011. I'd just like you to
15 review it and read it into the record, please.

16 A. The note is dated January looks like 8th,
17 2011. No vaginal leaking. Afebrile. Vital signs
18 stable. Fetal heart rate 145. Positive accelerations.
19 Biophysical profile, 8 out of 8. AFI, 11.5. White blood
20 count, 13,000. Hematocrit, 31.

21 My assessment: Intrauterine pregnancy at 26
22 weeks, 4 days. Preterm rupture of membranes. Monitor
23 for chorio.

24 MR. MITTELMARK: Okay. Mark that as the next
25 Defendant's exhibit.

(Defendant's Exhibit Numbers 6 and 7 were marked for identification.)

BY MR. MITTELMARK:

Q. I have another progress note which looks like it was signed by you dated January 19, 2011. Again, I would like you to look at it and read it into the record, please.

A. January 19, 2011. No contractions. No leaking. She was afebrile. Her vital signs were stable. Her blood -- Her biophysical profile was 8 out of 8. And her amniotic fluid index was 11. Her abdomen was soft, non-tender. Her fundus was soft. The fetal heart rate was 145. There were no contractions.

She was assessed as an intrauterine pregnancy at 26 weeks, 6 days. Preterm rupture of membranes. My plan was to monitor for fever or chorioamnionitis.

Q. So now, Dr. Lopez, I need you to assume that you have not seen Heather McCants from January 19, 2011 until the date of delivery. How would you describe Heather McCants as of January 19, 2011 as a patient that had been admitted to St. Mary's for one week?

MR. SILVA: Object to the form.

MS. WIDLANSKY: Join.

THE WITNESS: She is a high-risk obstetrical patient on the basis of her pregnancy in terms of

1 she had prematurely broken her bag of water, she
2 had a premature baby that had been seen by multiple
3 consultants.

4 I mean her list of high-risk factors include
5 those that belonged to her, which would include she
6 had a history of a previous rapid heart rate, she
7 had a history of two previous C-sections. She
8 has -- She was known to be approximately
9 350 pounds. She had failed her glucose screen, but
10 passed her three hour test.

11 She had demonstrated a positive AFP test,
12 which is an indicator of a bad potential baby
13 outcome.

14 She had been counseled by two perinatologists,
15 at least two OB/GYNs, myself and Dr. Tum, the
16 high-risk neonatal pediatrician about that she was
17 carrying a high-risk baby that had risk factors for
18 premature delivery, infection that could affect
19 multiple organ sites in the baby, the possibility
20 of other troubles related to her baby that dealt
21 with what -- you know, having to have a number of
22 lines put in, like IV lines, umbilical artery
23 catheters, having to have a lot of evaluations of
24 the baby's brain to see if there were hemorrhages
25 or if there was damage to the brain because of her

1 preexisting prematurity and preexisting preterm
2 rupture of membranes.

3 She was high risk of the high risk.

4 BY MR. MITTELMARK:

5 Q. Okay. So now I need you to assume that on
6 January 22, 2011 Ms. McCants was seen by a maternal
7 fetal medicine specialist and an OB physician.

8 On January 23rd Ms. McCants was seen by the
9 maternal fetal medicine specialist and an OB physician.

10 On January 24, 2011 Ms. McCants was seen by a
11 maternal fetal medicine specialist and an OB physician.

12 And on January 25th Ms. McCants was seen by a
13 maternal medicine physician at 8:15 p.m. and an OB
14 physician at 9:00 p.m.

15 Would you agree that Heather McCants was never
16 abandoned by any physician while she was a patient at
17 St. Mary's Medical Center?

18 MR. SILVA: Object to the form.

19 THE WITNESS: Yes.

20 BY MR. MITTELMARK:

21 Q. And that's the kind of attention that you
22 would expect a patient like Heather McCants to receive,
23 that is being seen by a maternal medicine specialist and
24 an OB physician every day while she was a patient at
25 St. Mary's?

1 A. Yes.

2 MR. SILVA: Object to the form.

3 BY MR. MITTELMARK:

4 Q. Now, Ms. McCants -- I'm sorry. Dr. Silva
5 showed you a nurses note which said that Dr. Tum was
6 rounding on Heather McCants at approximately 1:00 on the
7 afternoon of January 26, 2011. Do you recall that from
8 the nurses note?

9 A. Yes.

10 Q. What does that mean? Well, first of all, who
11 was Dr. Tum? And I know you describe -- Is it a him?

12 A. Yes, it is a him.

13 Q. Describe again Dr. Tum. Who was that?

14 A. Dr. Tum is an obstetrician who I cross-cover
15 with who has practiced at St. Mary's in excess of 30
16 years and was intimately involved with management of the
17 high-risk obstetrical patients from -- again, from
18 transferring in from other facilities.

19 He has an independent medical practice. He's
20 an M.D. And we share office space, and we share office
21 staff. But we have separate corporations.

22 Q. So based on your custom, habit, routine
23 cross-covering with Dr. Tum, what would you have
24 expected him to have done if he rounded on a patient
25 such as Heather McCants?

1 A. To have eval --

2 MR. SILVA: Object to the form. Go ahead.

3 THE WITNESS: To have evaluated her by taking
4 an interval history of what had happened since the
5 last time she was seen by an obstetrician. To
6 evaluate her by a physical examination to see if
7 her uterus was tender. To look at the objective
8 information, for example, the temperature chart,
9 the vital signs, the blood pressure, the pulse, to
10 look at the fetal heart rate, to look at whether or
11 not any of the fetal testing, the biophysical
12 profiles, if the CBC was indicating evidence of an
13 infection in the baby or in the mother.

14 And then assess the patient, which is
15 summarize some of the factors, the high-risk
16 factors. And then have a plan of care for
17 intervention or nonintervention depending on what
18 was indicated.

19 BY MR. MITTELMARK:

20 Q. Okay. I know it's two-and-a-half years ago,
21 but do you recall any conversations with Dr. Tum about
22 Heather McCants as a patient after he rounded on her at
23 approximately one p.m. in the afternoon?

24 A. No.

25 Q. And based on your experience, custom, habit

1 with Dr. Tum cross-covering for you, would you have
2 expected a phone call or some type of communication with
3 him had there been a problem with Heather McCants that
4 required immediate attention?

5 A. Absolutely.

6 MR. SILVA: Object to the form.

7 BY MR. MITTELMARK:

8 Q. Now --

9 MR. SILVA: You're talking about to -- prior
10 to the Cathflo injection?

11 MR. MITTELMARK: Prior to -- Between the time
12 that Dr. Tum rounded, any dates, any conversations
13 that he had with Dr. Tum. Because I know Dr. Tum
14 was at the delivery.

15 BY MR. MITTELMARK:

16 Q. So you would agree then, Dr. Lopez --

17 MR. MITTELMARK: If you need to take that --
18 I'm sorry.

19 THE WITNESS: Sorry. Can we go off the record
20 for just one second, please?

21 MR. MITTELMARK: Yes.

22 THE WITNESS: I apologize.

23 THE VIDEOGRAPHER: Off the record at 12:20.

24 (A recess was taken.)

25 THE VIDEOGRAPHER: We're now back on video

1 record at 12:28. This is the video tape three.

2 BY MR. MITTELMARK:

3 Q. I think I needed to clarify my last question
4 with you, Dr. Lopez. You don't recall any conversations
5 with Dr. Tum on January 26, 2011 prior to the delivery
6 of Heather McCants' child?

7 A. Correct.

8 Q. And had there been a concern on Dr. Tum's part
9 after he rounded on Heather McCants as a patient on
10 January 26th, based upon your custom and habit and
11 experience with him cross-covering for you, you would
12 have expected some type of communication, whether a
13 phone call or an e-mail, a text or some -- somehow the
14 two of you would have communicated?

15 A. Correct.

16 MR. SILVA: Object to the form. Asked and
17 answered.

18 BY MR. MITTELMARK:

19 Q. Now -- Oh, thank you.

20 One of the things I think you spoke about is a
21 biophysical profile. Could you describe for us what a
22 biophysical profile is?

23 A. A biophysical profile is an ultrasound to
24 evaluate parameters of an intrauterine pregnancy's
25 well-being. It's made up of four elements that are

1 scored from zero to two using an ultrasound machine.
2 The baby is evaluated for its movement, its breathing
3 motions, its amniotic fluid and its tone. And the
4 purpose of that test, it's one of the things that is a
5 tool to help us determine whether the baby is in a
6 stable environment or not.

7 Q. What I want to show you is a composite
8 exhibit, which will be my next one, of the biophysical
9 profiles that were performed on Heather McCants while
10 she was a patient at St. Mary's Medical Center.

11 (Defendant's Composite Exhibit Number 8 was
12 marked for identification.)

13 BY MR. MITTELMARK:

14 Q. I'd like you to take a look at those
15 biophysical profile results, and then read into the
16 record the one that was done on January 26, 2011.

17 A. Okay. I've now reviewed 12 biophysical
18 profiles. The biophysical profile dated January 26,
19 2011 indicates that the single intrauterine fetus is
20 noted to be in the vertex position. The fetal heart
21 rate of 147 beats per minute is seen. Amniotic fluid
22 index is noted to be 7.1. The placenta is in the
23 anterior position.

24 Biophysical profile is performed. Two points
25 are awarded for fetal breathing, fetal movement, fetal

1 tone, and qualitative amniotic fluid volume.

2 Biophysically score of 8 out of 8 points.

3 And this was read by Dr. Beckerman.

4 Q. And according to the biophysical profile
5 report that you just read it's timed at, what is it,
6 1435 or 2:35 p.m.?

7 A. Correct.

8 Q. So this report was read by -- performed and
9 read by -- was it Dr. Kellerman (sic), approximately one
10 hour before Heather McCants was taken to the OB/OR?

11 A. Correct.

12 Q. Now, based on your review of the biophysical
13 profiles, including the one for the date that
14 Ms. McCants delivered her child, what do they tell you?
15 Was there any change in that biophysical profile?

16 A. Well, as an ultrasound test for high-risk
17 pregnancies, that means pregnancies have problems. You
18 don't order a biophysical profile for a normal baby.
19 You only order it for babies that have problems.

20 That this baby under its circumstances had
21 sufficient fluid to be acceptable, sufficient movement
22 to be acceptable, physician -- sufficient breathing
23 motions to be acceptable, and physician -- sufficient
24 fetal tone to be in an acceptable state.

25 And this is one of the tests that would --

1 would say that given whatever problems this baby comes
2 to the table with, for what it has, what other risk
3 factors are there, at least in fetal well-being for that
4 moment it's -- it's doing as well as it can do.

5 Q. And we're talking as of 2:35 or approximately
6 one hour before Ms. McCants was taken to the OB/OR?

7 A. Correct.

8 Q. So we know from your review of the progress
9 notes and your review of the biophysical profile and
10 your knowledge and history of this patient that as of at
11 least 2:35 p.m. Heather McCants was in -- doing well?

12 A. Well, the baby is doing well for what it is.
13 It's still a baby that is premature. It's a baby that
14 has -- is living in an environment of a prolong rupture
15 of membranes. It's a baby that has received not only
16 antibiotics but has received steroids to help the lungs
17 mature. It's a baby that's one pound -- you know,
18 approximately two pounds at this point.

19 This is a baby who's under very serious
20 surveillance. If it were a criminal, it would have a
21 leg brace -- it would have an ankle bracelet. Okay.
22 This is a kid that's under a lot of supervision.

23 And for the risk factors that this baby is
24 carrying, it's doing as well as it could be doing for
25 this point.

1 Q. So to clarify what I mean by doing well, is
2 based on all of that supervision that has been ordered
3 for this patient, including examinations by you,
4 examinations by perinatologists, the nurses were doing
5 their job and taking care of Heather McCants; would you
6 agree?

7 MR. SILVA: Object -- object to the form.

8 THE WITNESS: Yes.

9 BY MR. MITTELMARK:

10 Q. At least as of up to 2:35 on January 26, 2011?

11 MR. SILVA: Object to the form.

12 THE WITNESS: Yes.

13 BY MR. MITTELMARK:

14 Q. So we know that Heather McCants had a PICC
15 line. Do you know as you sit here why she was ordered
16 to have a PICC line?

17 A. She was ordered to have a PICC line because
18 she required to have a PICC line. There was an
19 inability because of the physical characteristic of
20 Mrs. McCants, her veins were not readily available to be
21 cannulated for IV hydration, for medication
22 administration.

23 And because she had been previous cesarean
24 section and things can sometimes change rapidly, this is
25 a patient who constantly needed a predictable, stable IV

1 access. So rather than making a human pincushion after
2 her, in other words, sticking her till she's black and
3 blue, a clinical decision was made that she is going to
4 need to have an IV access that's called a PICC line.

5 A PICC line is ordered when it's necessary.
6 It's a higher level of care than the normal typical
7 patient would have. It's not something everybody gets.
8 It's only those people that absolutely require it get.

9 And she was one of those people that had a
10 requirement on the basis of her physical characteristics
11 and the treatments that were administered to her that
12 she needed to have IV access and PICC line was
13 appropriate to be ordered for her.

14 Q. In this case, Heather McCants' case, the night
15 before she delivered at 8:20 p.m. Dr. Stoessel wrote an
16 order for Cathflo. That is not something you had
17 anything to do with; am I correct?

18 A. That's correct.

19 Q. And I know you testified about your knowledge
20 of Patrick Hare. You have experience at St. Mary's with
21 the PICC Team, right, for your patients?

22 A. Yes, I have.

23 Q. So it wouldn't surprise you that Patrick Hare
24 showed up on January 26th to take care or to fulfill
25 Dr. Stoessel's order, right?

1 A. Correct.

2 Q. Okay. Now, as I understand your first
3 involvement, and I'm going to use that word involvement,
4 your first knowledge of Heather McCants needing some
5 type of intervention by you was when you got a phone
6 call?

7 A. Correct.

8 Q. And according to the testimony yesterday, the
9 phone call was made and you answered right away. That's
10 the type of physician you are, right?

11 A. Yes.

12 Q. And as soon as you got that phone call, you
13 made a decision that you were going to come to
14 St. Mary's Medical Center, right?

15 A. Yes.

16 Q. And there was no delay on your part, correct?

17 A. Correct.

18 MR. SILVA: Object to the form.

19 BY MR. MITTELMARK:

20 Q. Now, what happened prior to you getting that
21 phone call, you have no knowledge, right?

22 A. Well --

23 Q. Let me ask it this way: And, again, prior to
24 you getting that phone call, you had no knowledge of
25 what was transpiring with Heather McCants as a patient?

1 A. Correct.

2 Q. And I'm sorry to rehash what you testified to
3 in your first deposition, but can you tell us again what
4 you recall about that phone call when you first heard
5 about Heather McCants?

6 A. My response was that I identified that I was
7 not in the hospital, that I would be on my way, and that
8 she needed to be prepared for a cesarean section.

9 Q. Okay. Now, based upon your review of the
10 records, would you agree that after the Cathflo was
11 administered a rapid response was called?

12 A. Yes.

13 Q. And after the rapid response was called, the
14 nurse taking care of the patient was in
15 Heather McCants's room, Patrick Hare the PICC Team
16 line -- PICC Team leader was in Heather McCants's room,
17 Dr. Sanches an OB/GYN physician was in Heather McCants's
18 room, Marilyn Wester, a labor and delivery nurse working
19 on the antenatal floor was in Heather McCants's room,
20 and Carol Seamon, the assistant supervisor that day, was
21 in Heather McCants's room?

22 A. Correct.

23 Q. And that based on your experience, hopefully
24 you don't have too much experience with Rapid Response
25 Team, are appropriate personnel to respond to a rapid

1 response?

2 MR. SILVA: Object to the form.

3 THE WITNESS: Correct.

4 BY MR. MITTELMARK:

5 Q. And, additionally, we had a perinatal
6 respiratory therapist, Luis Mosos. Do you know Luis
7 Mosos?

8 A. Yes.

9 Q. Okay. So he also showed up. And you had a
10 respiratory therapist by the name of Winthrop. Do you
11 know who Neil Winthrop is?

12 A. Yes.

13 Q. So he's also showing up for the rapid
14 response. And, again, these are appropriate personnel
15 to take care of any issues if there is a respiratory
16 arrest or respiratory distress, correct?

17 A. Yes.

18 MR. SILVA: Object to the form.

19 BY MR. MITTELMARK:

20 Q. Now, I know it is two-and-a-half years ago.
21 Do you recall what Nurse Duckworth said about the fetal
22 monitoring strips that she had reviewed on Dominic
23 Shelton after the rapid response was called?

24 MR. SILVA: Object to the form. Assumes facts
25 not in evidence. Misstates her testimony.

1 Go ahead.

2 THE WITNESS: While I don't recall
3 independently every detail of what she told me, it
4 was my understanding that the baby had undergone a
5 prolonged deceleration.

6 BY MR. MITTELMARK:

7 Q. Okay. And what does that mean to you as a
8 board certified OB/GYN physician?

9 A. It means that there has been a change in the
10 fetal status from a heart rate that was normal to a
11 heart rate that had decelerated below 80 beats per
12 minute for more than two minutes and was ongoing.

13 This happens a lot. Especially in patients
14 who are having low volumes of amniotic fluid that have
15 had premature ruptures of membranes when sometimes the
16 mother may change position and the baby inadvertently
17 entangles itself in the umbilical cord.

18 And usually they're the things that the
19 hospital has prearranged for nurses to be allowed to do
20 which as a whole we call that body of maneuvers as
21 intrauterine resuscitative measures would be to
22 reposition the patient, to give the patient -- the
23 mother oxygen, to increase the IV fluids on the patient,
24 and, obviously, to alert all the other members of the
25 medical staff.

1 All of these things were done by
2 Nurse Duckworth. And the purpose of that is again
3 hopefully by repositioning the patient, administering
4 oxygen, increasing the amount of fluid volume, the
5 overwhelming majority of these decelerations
6 self-correct and the pregnancy continues.

7 In some cases they don't self-correct. And in
8 those cases an emergent or an urgent delivery is
9 performed after the intrauterine resuscitative efforts
10 have failed for example.

11 Q. So I just want to be clear because I -- I
12 think I understand. You don't recall if the rapid
13 response was called at 3:12 and Michelle Duane, a nurse
14 practitioner, shows up at 3:13; you don't know anything
15 about the times that took place prior to your arrival at
16 St. Mary's Medical Center?

17 MR. SILVA: Object to the form.

18 THE WITNESS: Correct.

19 BY MR. MITTELMARK:

20 Q. Now you talked about, or at least I talked
21 about the fetal monitoring strips. And I know you
22 testified earlier that you had reviewed them. What I
23 would like to do is show you those fetal monitoring
24 strips while Ms. McCants was in her room and immediately
25 prior to and after the rapid response. And I would like

1 to get your opinion about what these fetal monitoring
2 strips show. Is that okay?

3 A. Yes.

4 MR. SILVA: And on the record I'm going to --
5 I'm going to object to this entire line of
6 questioning. The doctor has already testified that
7 he did not review those fetal heart monitor strips
8 prior to ordering the C-section. It's
9 inappropriate for you to have him review them now
10 after the fact.

11 MR. MITTELMARK: Objection overruled.

12 BY MR. MITTELMARK:

13 Q. Dr. Lopez, what I'm purporting to show you is
14 fetal monitoring strips that were taken on Ms. McCants's
15 fetus on January 26th prior to and shortly after the
16 rapid response was called. And I would like you to just
17 sit and look at them, and if you could tell us what they
18 show to you.

19 And, again, fetal monitoring strips is
20 something that you review as part of your performance of
21 your OB/GYN duties, correct?

22 A. Yes. Starting with panel 75108, the fetal
23 heart rate baseline is in the 150s. And there are some
24 accelerations, which are signs that the baby is happy in
25 the environment.

1 There is a couple of panels where it is
2 uninterpretable. And what I mean by that is that the
3 record doesn't indicate what the heart rate is actually
4 doing during panel 75111 and 75112.

5 An interpretable panel is in 75113. And the
6 heart rate shows acceleration to the 160s, which shows
7 happiness on the part of the baby.

8 Then in panel 75115, which is just before
9 1430, there is a baseline in the 150s with an
10 acceleration up to the 170s that would meet the 15-by-15
11 criteria of a reactive non-stress test.

12 That's followed by about two minutes of
13 uninterpreted fetal heart rate pattern -- pattern.

14 Then on 75117 and 75118 the fetal heart rate
15 appears to show multiple accelerations.

16 Panel 75119 fetal heart rate has accelerations
17 with the baseline approximately 150.

18 Panel 75121 is reassuring. Meaning the baby
19 appears to be in a stable, happy environment. Fetal
20 heart rate's got a baseline of around 150, 155, has
21 variability, has accelerations.

22 This continues in panel 75123 and 75124, panel
23 75125.

24 Panel 75126 again demonstrates a 15-by-15
25 acceleration indicating the baby is in a happy

1 acceptable environment.

2 Panel 75127 the fetal heart rate declines to
3 the 90s, and then decelerates to below the 60s, and it
4 stays in 75128.

5 It appears to be recorded perhaps at the 110
6 starting on panel 75129.

7 In 75130 it's going to 130 beats per minute
8 and stays in the 130s until panel 75132 where you see
9 the heart rate in the 150s.

10 And then the strip ends in one panel, 75133.

11 Q. So now having had an opportunity to look at
12 what I'll call laser color copies of the fetal
13 monitoring strips - and we'll go ahead and mark that as
14 composite exhibit, whatever my next exhibit is - does
15 that comport with your operative report and the
16 discharge summary that you prepared on Heather McCants?

17 A. Yes.

18 (Defendant's Composite Exhibit Number 9 was
19 marked for identification.)

20 BY MR. MITTELMARK:

21 Q. And going to your discharge summary, which I
22 believe was marked as an exhibit. And I forget what
23 Plaintiff's exhibit it was.

24 MS. WIDLANSKY: I have a marked copy --

25 MR. MITTELMARK: Oh, great.

1 MS. WIDLANSKY: -- I can show him.

2 MR. MITTELMARK: Thank you.

3 BY MR. MITTELMARK:

4 Q. Can you tell from that what happened to
5 Ms. McCants after she delivered Dominic Shelton? Just
6 the last few sentences.

7 And it's not a -- She was discharged right?

8 A. Yes. This is the discharge note. You know
9 she underwent an emergency repeat C-section because of
10 prolonged fetal deceleration and persistent fetal
11 tachycardia under spinal anesthesia on 1/26/2011.

12 CT angio. revealed no evidence of acute
13 pulmonary embolism. She remained hemodynamically
14 stable.

15 And then she was discharged on prenatal
16 vitamins, iron sulfate. She's not to have sex, not to
17 lift, and her routine discharge instructions were given.

18 Q. Right. And you told us that the word
19 emergency should be emergent?

20 A. Correct.

21 Q. And the word fetal tachycardia should be
22 maternal tachycardia.

23 MR. SILVA: Object to the form.

24 BY MR. MITTELMARK:

25 Q. Right?

1 A. Yes.

2 Q. So based on your recollection of the delivery
3 of Heather McCants's son Dominic Shelton in this case,
4 was there anything out of the ordinary that occurred in
5 the delivery room?

6 MR. SILVA: Object to the form.

7 THE WITNESS: No.

8 BY MR. MITTELMARK:

9 Q. And had something unusual or untoward happened
10 in the delivery room, you most likely would have
11 remembered that based on your career as a board
12 certified OB/GYN physician who has delivered thousands
13 if not tens of thousands of infants?

14 MR. SILVA: Object to the form.

15 THE WITNESS: Correct.

16 BY MR. MITTELMARK:

17 Q. So when you left according to the -- I forget
18 what Plaintiff's exhibit it was. You left the delivery
19 room at 4:15 -- Oh, I'm sorry. It was the access
20 denied/granted and other badge events document.

21 So when you left the delivery room at 4:15
22 p.m. on January 26, 2011, as you sit here today can you
23 remember what you were thinking about Heather McCants as
24 a patient?

25 MR. SILVA: Object to the form.

1 THE WITNESS: Well, I had an ongoing concern
2 because she had had a change in status with her
3 heart rate going high and the possibility of her
4 having a pulmonary event that could put her life in
5 jeopardy.

6 But I was comforted in knowing that the
7 hospitalist was taking charge of her, had ordered
8 all of the testing to rule out those things that
9 could have harmed Mrs. McCants, and had put her in
10 special surveillance in the intensive care unit.

11 And, again, in the intensive care unit at
12 St. Mary's, we're talking about a major trauma
13 center. You get real good care. You get really
14 good evaluations and really good care because it's
15 a place where high-risk people frequently are
16 brought to be cared for.

17 So while I had concerns also of her baby,
18 because I knew her baby was less than -- You know,
19 this is not a 7-pound baby. We're talking about a
20 2-pound baby, you know. We're not talking about a
21 baby whose brains are ready to go or the lungs are
22 ready to go and is going to be able to feed itself.

23 I knew that this baby was going to have a
24 protracted battle, because I've taken care of other
25 patients like Ms. McCants's baby. I've delivered

1 babies that had to be delivered prematurely.

2 But I felt that she had been appropriately
3 cared for and informed about what was before her.
4 Except for, you know, what was going on with her
5 personally on the day of delivery.

6 BY MR. MITTELMARK:

7 Q. So when you left that delivery room on
8 January 26, 2011, you knew that there was a mechanism in
9 place for Ms. McCants to be seen by a pulmonologist, a
10 maternal fetal medicine expert -- excuse me, physician,
11 Dr. Deutsch that we talked about earlier, that she was
12 going to get the VQ scan and the Doppler of the lower
13 extremities, and that she was going to be in the ICU
14 where she was going to be given one-to-one care, true?

15 MR. SILVA: Object. Object to the form.

16 THE WITNESS: Correct.

17 BY MR. MITTELMARK:

18 Q. And you knew from your presence in the
19 delivery room that there was a board certified
20 neonatologist Dr. Ambroise present, correct?

21 A. Yes.

22 Q. And that you had already ordered a
23 neonatologist consult. So they were aware of the
24 potential for having this child brought to their --
25 brought to the St. Mary's NICU, right?

1 A. Yes.

2 Q. And that Dominic Shelton, the infant that you
3 delivered, was going to be taken not to anywhere other
4 than the NICU at St. Mary's Medical Center, right?

5 A. Correct.

6 Q. So I have to ask you these questions, and I
7 apologize for asking them. But when you treated
8 Heather McCants from January 12, 2011 to January 26,
9 2011 when you delivered her son, did you have actual
10 knowledge of the wrongfulness of your conduct and the
11 high probability that injury or damage to Ms. McCants
12 would result, and despite that knowledge you
13 intentionally pursued a course of conduct that resulted
14 in injury either to Ms. McCants or her infant, Dominic
15 Shelton?

16 MS. WIDLANSKY: Form.

17 MR. SILVA: Object to the form.

18 THE WITNESS: No, I did not.

19 BY MR. MITTELMARK:

20 Q. And do you believe as you sit here today after
21 having reviewed the St. Mary's Medical Center records on
22 Heather McCants's January 26, 2011 admission that your
23 conduct was so reckless that it constituted a conscious
24 disregard or indifference to the life, safety or rights
25 of Heather McCants or her infant son, Dominic Shelton?

1 MR. SILVA: Object to the form.

2 THE WITNESS: Absolutely not.

3 MR. MITTELMARK: Thank you, Dr. Lopez. I don't
4 have anything further.

5 MR PUYA: Oh, do you have one there?

6 MR. MITTELMARK: I do.

7 CROSS-EXAMINATION

8 BY MR PUYA:

9 Q. Good afternoon, Dr. Lopez. Again my name is
10 Keith Puya. I represent Dr. Lane. I just have a few
11 questions for you, sir.

12 A. Okay.

13 Q. I appreciate your time.

14 The first question I'd like to ask you is as
15 follows: Do you as the attending obstetrician, the
16 obstetrician who delivered Dominic Shelton via cesarean
17 section have any criticisms at all with respect to the
18 type and administration of anesthesia that was provided
19 to Ms. McCants in preparation for your surgery?

20 MR. SILVA: Object to the form.

21 THE WITNESS: No, I do not.

22 BY MR PUYA:

23 Q. Do you believe as the attending obstetrician
24 preparing to deliver this baby that there was any delay
25 in the performance of the cesarean section as a result

1 of anesthesia from your perspective?

2 MR. SILVA: Object to the form.

3 THE WITNESS: Absolutely not.

4 BY MR PUYA:

5 Q. From your observation, I heard you testify
6 over the course of a couple of different sessions today,
7 from your observation as the attending obstetrician is
8 it your opinion that everyone involved as the team in
9 getting Ms. McCants ready for this cesarean section
10 acted appropriately, swiftly and as necessary to get
11 this baby delivered as soon as possible?

12 MR. SILVA: Object to the form.

13 THE WITNESS: Yes.

14 BY MR PUYA:

15 Q. You told us before that this was an emergent
16 or urgent C-section; was that your term?

17 A. Yes.

18 Q. Okay. Now let me ask you this: What was the
19 actual indication for the cesarean section? In other
20 words, was it -- was it the prolonged seven minute
21 deceleration that the nurses noted following the issue
22 regarding the Cathflo, or was it something else that led
23 to your decision to ready Mrs. McCants for a cesarean
24 section delivery?

25 A. It was that Mrs. McCants her heart rate went

1 into the 160s and 150s persistently beyond whatever
2 event happened on the floor. And she had multiple risk
3 factors for a possible pulmonary embolism.

4 In other words, one of the working diagnosis
5 of why her heart rate would suddenly accelerate to
6 double the normal rate is that a patient like Mrs.
7 McCants who was 350 pounds, who had been bedridden for
8 more than two weeks, who had had some sort of reaction
9 to possibly some medication on the floor and whose heart
10 rate had now accelerated to double normal was going to
11 need to be thoroughly evaluated by tests that you kind
12 of can't do when somebody is pregnant. You can't do a
13 ventilation perfusion scan for -- to determine her
14 health, whether or not she had a clot. You know you
15 can't do some of the better tests. She might have been
16 physically too large to do a spiral CT exam. She may
17 not fit in the machine.

18 And in order to maximize the safety of her,
19 Ms. McCants, as well as her baby. Because her baby had
20 had an intrauterine event that she -- that it appeared
21 to be resuscitating from using the maneuvers that are
22 standard. But it was about Mrs. McCants. She has in
23 trouble. She was in a lot of trouble.

24 And we could be sitting here today talking
25 about a completely different problem that involved

1 mostly Mrs. McCants had we not delivered her baby and
2 done the testing and taken the precautions to ensure her
3 health and well-being.

4 Q. So stated differently, please correct me if
5 I'm misquoting you, that your reasoning for ordering an
6 emergent or urgent cesarean section dealt primarily with
7 your concerns about Mrs. McCants.

8 MR. SILVA: Object to the form.

9 BY MR PUYA:

10 Q. Is that a fair statement?

11 A. Correct.

12 Q. Not to disregard the well-being of the fetus,
13 but your primary concern when you received that phone
14 call when you were at this -- the other hospital down
15 the street about what had happened to Mrs. McCants, your
16 reasoning for making the decision to ready her for a
17 cesarean section was based upon what happened to her and
18 your concerns about her well-being and physical status.

19 MR. SILVA: Object to the form.

20 MS. WIDLANSKY: Form.

21 BY MR PUYA:

22 Q. Is that a fair statement?

23 MR. BLOOM: Join.

24 THE WITNESS: Yes.

1 BY MR PUYA:

2 Q. Now, did you understand that Mrs. McCants, and
3 I'm going just to make sure I understand this, do you
4 believe that she had a respiratory arrest or that she
5 had respiratory failure?

6 MR. SILVA: Object to the form.

7 BY MR PUYA:

8 Q. Or is there a difference in your mind, and if
9 there is, tell me if there is, please.

10 A. For all intents and purposes to me they were
11 the same. She had an event, a respiratory event. Some
12 may have described it one way. Others who were closer
13 to her may have described her in a different way. But
14 in either event, she had an event.

15 Q. And that event, if you will, affected her
16 hemodynamics, did it not?

17 A. Oh, yes.

18 Q. Okay.

19 A. It affected her hemodynamics to the point that
20 an experienced nurse who carries -- who cares for
21 patients in a career-wide basis set -- set the alarm for
22 the rapid response and for as much supportive care as
23 could possibly be mustered to attend to her patient's
24 care.

25 Q. Did you conclude or did you know rather in

1 talking to -- Was it Nurse Duckworth who actually spoke
2 with you over the phone?

3 A. Yes.

4 Q. That there had been evidence on the fetal
5 monitor tracings of some period of decelerations with
6 respect to the fetal heart rate?

7 A. Not before the Cathflo, but afterwards, yes.

8 Q. Concomitant with the event regarding the
9 Cathflo --

10 A. Correct.

11 Q. -- fair enough?

12 And that wouldn't be an unexpected finding,
13 however? If the mother, maternal blood flow or the
14 maternal system is being affected it could carry over
15 into the fetal system too; could it not?

16 A. Correct. And you can see this from something
17 as benign a process as the mother rolls flat on her back
18 or that the mother passes out and lands on her back or
19 that the mother repossessions herself on -- you know,
20 flat on her back.

21 But the mother has -- You know, among the
22 physical characteristics of the mother is that she
23 weighs 300 plus pounds. And that weight comes and
24 compresses on the uterus and possibly the umbilical cord
25 was somewhere in proximity of where the baby's body

1 would compress it.

2 Q. And you -- Obviously you've before
3 January 26th of 2011 have probably performed, I'll let
4 you give me the number, but no doubt a significant
5 number of cesarean sections; is that a fair statement?

6 A. Yes.

7 Q. And many of those and, unfortunately, probably
8 a fair number of those have been under emergent or
9 urgent situations?

10 A. Yes.

11 Q. Have you in the past been comfortable using a
12 spinal anesthesia in that setting?

13 A. Yes, in many --

14 MS. WIDLANSKY: Form.

15 THE WITNESS: When it's indicated --

16 MR. SILVA: Object to the form.

17 THE WITNESS: -- a spinal -- spinal should be
18 used.

19 BY MR PUYA:

20 Q. Okay. And that's a safe and effective
21 alternative to general anesthesia --

22 MR. SILVA: Object --

23 BY MR PUYA:

24 Q. -- and certainly would allow you to conduct
25 your cesarean section as needed.

1 MR. SILVA: Form.

2 BY MR PUYA:

3 Q. True?

4 MS. WIDLANSKY: Join.

5 THE WITNESS: Yes.

6 BY MR PUYA:

7 Q. So in this particular case you're not critical
8 or you don't fault Dr. Lane for administering the
9 subarachnoid block or the spinal anesthesia to ready
10 Mrs. McCants for your surgery, do you?

11 A. No.

12 MR. SILVA: Form.

13 BY MR PUYA:

14 Q. And you're not suggesting to us or to this
15 jury if this is read that the anesthesia in any way
16 delayed your performance of the cesarean section, are
17 you?

18 A. No.

19 MR. SILVA: Object to the form.

20 BY MR PUYA:

21 Q. Did you happen to -- I mean you saw the baby
22 when you delivered the baby. I think last time you told
23 us -- I think you used the word -- I don't know if it
24 Superman or the baby looked pretty good?

25 A. The baby was a rock star.

1 Q. A rock star. I mean you've been involved --
2 And, again, don't take this negatively. But you've been
3 involved I'm sure in cases where the outcome hasn't been
4 very good upon delivery?

5 A. That's correct. I've been involved where
6 babies are in real trouble, and I've been involved in
7 cases where babies didn't make it.

8 Q. So you have a benchmark. I mean you have a
9 knowledge base where you've seen that outcome in which
10 to compare this case to?

11 MR. SILVA: Object to the form.

12 THE WITNESS: Yes.

13 BY MR PUYA:

14 Q. Okay. So with that being said, was there
15 anything that suggested to you when you delivered
16 Dominic Shelton, took him out of the womb and handed him
17 to the neonatal personnel that there was any suggestion
18 or thought to you that this baby was suffering from some
19 hypoxic ischemic event?

20 MR. SILVA: Object to the form.

21 THE WITNESS: Absolutely not. By the national
22 standards that we use, if you're going to use Apgar
23 scores below five at five minutes indicates a baby
24 in trouble.

25 This baby had a score of eight at one minute

1 and a eight at five minutes. This baby was
2 surrounded by a high-risk pediatric neonatologist,
3 a respiratory therapist, and possibly another nurse
4 at the time of delivery that they all looked at the
5 baby, and they said the baby looks great. The baby
6 was crying. The baby was wiggling, moving around
7 and kicking.

8 Now, we knew -- Look, we knew what we were
9 dealing with. Babies at 27 weeks, babies at
10 2 pounds are not like 40-week baby's, full-term
11 babies. They're not like 7 pound, 8 pound babies
12 like Ms. -- or not like 8-pound babies like
13 Ms. McCants had had previously.

14 This is a baby whose brain wasn't ready. It's
15 lungs wasn't ready. It's GI tract wasn't ready.
16 And it had a long, hard trip ahead of itself.

17 But as far as how it was when it was born,
18 there was zero evidence of an asphyxiated baby. It
19 doesn't meet the national standards; doesn't meet
20 the local standards.

21 BY MR PUYA:

22 Q. So relatively speaking here given the
23 gestational age of 27 weeks and a few days, this baby's
24 Apgar scores in your mind were certainly not consistent
25 with any type of hypoxic ischemic event; is that a fair

1 statement?

2 MR. SILVA: Object to the form.

3 THE WITNESS: Yes.

4 BY MR PUYA:

5 Q. And you mentioned to us before, was the baby
6 getting surfactant? Was the baby getting some type of
7 steroid for lung maturation?

8 A. Before the baby was born, this baby received
9 two doses of steroids to accelerate fetal lung maturity
10 as is appropriate in someone -- as is appropriate in a
11 baby who is thought to be at risk of being born before
12 the lungs were going to be ready.

13 Also received several courses of the
14 appropriate antibiotic to protect it from the ravages of
15 a possible infection in light of the fact that her (sic)
16 mother's bag of water broke and was broken for a long
17 time.

18 Q. You mentioned to us Mrs. McCants' body
19 habitus. I think you said that she was close to or in
20 excess of 350 pounds?

21 A. That's correct.

22 Now, look, I'm a big guy. I'm not -- I'm not
23 making any judgments about people's sizes. I'm a big
24 guy. Big people carry big risk.

25 Q. And you mentioned too about having to tape her

1 panniculus, the weight or the fat, if you will, that
2 drapes over the surgical site?

3 A. That's right.

4 Q. What other things that you could tell us need
5 to be done in order to ready her for surgery in order to
6 conduct a safe procedure, not only for the mother, of
7 course, which was your primary concern it sounds like,
8 but also for the well-being of the baby?

9 A. Well, we all recognize from experience that it
10 was 3:00 in the afternoon. It's after lunchtime at
11 St. Mary's. Now it's -- Lunch at St. Mary's doesn't
12 show up at 12:00. It might show up at 1:00; it might
13 show up 1:30, but it shows up. And before Ms. McCants
14 had her event, she had had lunch. Now, how much lunch
15 she had had, I didn't personal know. But I know that
16 she had completed her lunch.

17 I had seen Ms. McCants physically. Like I
18 said, I'm a big person myself. Ms. McCants had a lot of
19 physical features that have to be taken into
20 consideration before she has surgery. She's a -- She's
21 350 pounds or so. She has a neck that's short. Now,
22 I'm not -- Again, I'm not trying to say that that's --
23 that's a bad thing. It just is what it is.

24 And we certainly already knew that Ms. McCants
25 was in trouble. Her heart rate was already twice what

1 the rate it was supposed to be.

2 If she was car, like I said, on a highway,
3 instead of going 55, she's going 110. And she had been
4 going 110 for a little while here. To the point where
5 we needed to get her delivered and get her stable. And
6 we certainly didn't need to go out of our way to make
7 more troubles for Ms. McCants. So the important things
8 that were needed to be done were taken into
9 consideration.

10 Now, about her stomach, okay, she had a big
11 stomach, not because her baby was full term. She had a
12 big stomach because she had a big stomach. And that gut
13 when you lay them down to do an operation on is going to
14 sit on their stomach. So if there is something on their
15 stomach, you've got to be careful that you have
16 protected that patient's airway. You do not want this
17 patient to die from aspiration, from vomiting or
18 suffocation or other issues that may be related to a
19 short neck, a full stomach and a big gut.

20 So among mature, experienced obstetricians and
21 anesthesiologists, the form of anesthesia I expected her
22 to have was a spinal. She just ate. She's big. You
23 don't need any more trouble than you already had on the
24 table.

25 And so I had absolutely no issue with

1 Dr. Lane's decision to proceed with a subarachnoid
2 anesthesia.

3 Q. Okay. The last question I have, and just you
4 seem very passionate about what you do; is that a fair
5 statement?

6 A. I love what I do. I feel honored to have been
7 able to be a physician, to have been able to be of
8 service not only to our community but throughout a big
9 chunk of the State of Florida over a very long period of
10 time I might add - same thing for Dr. Tum - and be part
11 of a team of people that do this often.

12 Q. And I guess my point really is you seem to me
13 to be the type of person that if you were not happy with
14 what was being done or you felt things weren't being
15 done as quick as you wanted them, as quick as
16 Dr. Berto Lopez wanted things being done for your
17 patient, are you the type of person that speaks up and
18 lets people know that, you know, you want things done
19 differently?

20 MR. SILVA: Object to the form.

21 THE WITNESS: Oh, absolutely. I'm not -- I'm
22 not a shrinking violet. If things weren't right,
23 people would have heard about it. That didn't
24 happen here.

25 Everybody did exactly what they were supposed

1 to do in a professional and timely manner. And
2 these shadows and wild -- wild accusations, they're
3 not going to hold up.

4 MR. PUYA: Thank you very much, Dr. Lopez. I
5 appreciate your time.

6 MR. BLOOM: I have one question.

7 MR. SILVA: Go ahead.

8 MR. BLOOM: Thank you.

9 CROSS-EXAMINATION

10 BY MR. BLOOM:

11 Q. Good afternoon, Dr. Lopez.

12 A. Good afternoon.

13 Q. I represent Dr. Sanches as you may know. I
14 think Mr. Puya sort of roundabout asked the question I'm
15 going to ask. Do you have any criticisms of any of the
16 actions that Dr. Sanches took on January the 26th?

17 A. No.

18 MR. SILVA: Object to the form.

19 MR. BLOOM: Thank you.

20 MS. WIDLANSKY: Next? Any questions?

21 MR. SILVA: Yes, I have some questions for
22 you.

23 REDIRECT EXAMINATION

24 BY MR. SILVA:

25 Q. When you initially applied for privileges at

1 this hospital, what did you have to do?

2 A. I had to --

3 MS. WIDLANSKY: Form. Outside the scope.

4 Go ahead.

5 BY MR. SILVA:

6 Q. Go ahead.

7 A. I had to fill out paperwork indicating my
8 knowledge, training and experience, detailing my
9 knowledge, training and experience, give references,
10 gives logs of previous experience for the privileges
11 that I had been requesting, and to fill out a
12 delineation of privileges page, which indicated that I
13 wanted to be an obstetrician/gynecologist.

14 Q. And you had to do that specifically for this
15 hospital, St. Mary's Medical Center?

16 A. For each of the hospitals. It's a lot
17 boilerplate, the same.

18 Q. Do you have privileges at Bethesda?

19 A. No, I do not.

20 Q. Have you ever applied at Bethesda Hospital --

21 A. No.

22 Q. -- for privileges?

23 A. No, I haven't.

24 Q. Are you familiar with their staff bylaws at
25 Bethesda?

1 MS. WIDLANSKY: Object to form.

2 THE WITNESS: No.

3 BY MR. SILVA:

4 Q. Are you familiar with the policies and
5 procedures for the medical staff at Bethesda Hospital?

6 MS. WIDLANSKY: Form.

7 THE WITNESS: No, I'm not.

8 BY MR. SILVA:

9 Q. Okay. Are you familiar with the medical staff
10 bylaws at St. Mary's Medical Center?

11 A. Yes.

12 Q. Are those medical staff bylaws created by
13 St. Mary's Medical Center that require physicians to
14 conduct themselves in a certain situation so that they
15 can see their patients and take care of their patients
16 at this -- at this hospital?

17 MS. WIDLANSKY: Form.

18 THE WITNESS: Yes.

19 BY MR. SILVA:

20 Q. Okay. And does St. Mary's also require of
21 their physicians that have privileges like yourself,
22 admitting privileges and surgical privileges that you
23 abide by St. Mary's Medical Center's policies and
24 procedures?

25 MS. WIDLANSKY: Form. Asked and answered.

1 Outside the scope of cross.

2 BY MR. SILVA:

3 Q. You can answer.

4 A. Yes.

5 Q. The -- I think Mr. Mittelmark was asking you
6 earlier you were consulted to take care of Heather
7 McCants by Dr. Stoessel?

8 A. I believe it was in part by Dr. Stoessel,
9 correct.

10 Q. Okay. Now, had you ever taken care of
11 Heather McCants prior to her being admitted to
12 St. Mary's Medical Center?

13 A. I don't think so, no.

14 Q. Okay. You never took care of her prior two
15 births that she had?

16 A. Correct.

17 Q. Okay. Were you aware that the two births that
18 she had prior to this were C-sections?

19 A. Yes.

20 Q. So this baby was going to be required to be
21 delivered by C-section regardless of the prenatal
22 outcome, correct?

23 A. Yes.

24 MS. WIDLANSKY: Form.

25

1 BY MR. SILVA:

2 Q. Why?

3 A. Because she had multiple risk factors. Having
4 had two previous cesarean sections, she was at a greater
5 risk of a uterine rupture than someone had had a single
6 cesarean section.

7 Additionally, at various times through her
8 hospitalization, her baby was not always head down.
9 Sometimes it was sideways. Sometimes it was I
10 believe -- I mean I may not be a hundred percent
11 correct, but it was in a position other than head down,
12 vertex.

13 Q. Do you know if St. -- if St. Mary's Medical
14 Center requires a neonatology consult for all patients
15 that are to have a C-section?

16 A. I don't know. I do know that they are --
17 neonatologists are present at every delivery or they're
18 proxies, meaning a nurse practitioner or...

19 Q. Has a nurse practitioner or a neonatologist
20 always been present at your C-section deliveries at
21 St. Mary's Medical Center?

22 A. Yes.

23 Q. And so you would have expected a
24 neonatologist or nurse practitioner to be present at the
25 delivery of Heather McCants' baby on January 26, 2011,

1 correct?

2 A. Yes.

3 Q. I think you testified earlier that you take
4 all comers to St. Mary's Medical Center, right?

5 A. Yes.

6 Q. And that's because you have privileges at this
7 hospital, right?

8 MR. MITTELMARK: Object to the form.

9 THE WITNESS: That's one of the reasons, but
10 there are others.

11 BY MR. SILVA:

12 Q. Okay. Do you take all comers to Bethesda
13 Hospital in Palm Beach County?

14 A. I don't go to Bethesda.

15 Q. Okay. So you can't take any admissions at
16 Bethesda because you don't have privileges there,
17 correct?

18 A. Correct.

19 Q. But you can take all comers to this hospital
20 because you have privileges at this hospital?

21 A. Correct. To a point, but there are other
22 reasons.

23 Q. Okay. Did St. Mary's privilege you for --
24 privilege you for any specific or special privileges
25 when you initially obtained privileges there?

1 MS. WIDLANSKY: Form.

2 THE WITNESS: No.

3 BY MR. SILVA:

4 Q. Have you obtained any additional privileges
5 over the years at St. Mary's?

6 A. Only in those areas where technology has
7 evolved, for example, laser, carbon dioxide laser,
8 possibly some of the new advancements in surgeries where
9 you have to have documentation of experience.

10 Q. Okay. You're not a board certified
11 neonatologist, are you?

12 A. No.

13 Q. You're not a board certified maternal fetal
14 specialist, are you?

15 A. No.

16 Q. Are you a board certified maternal medicine
17 physician?

18 A. No.

19 Q. Have you ever been a hospitalist at a hospital
20 before?

21 A. For internal medicine, no.

22 Q. Yes. Are you a board certified cardiologist?

23 A. No.

24 Q. Board certified pulmonologist?

25 A. No.

1 Q. When Heather McCants came into the hospital at
2 St. Mary's, she was initially put on broad spectrum
3 intravenous antibiotics?

4 A. Yes.

5 Q. And then those were discontinued because she
6 was showing no signs of the infection; isn't that true?

7 A. Correct. And the course that would be a
8 treatment for the beta strep that she did have evidence
9 of infection of had been completed.

10 Q. Right. And that's -- that's a finding in
11 pregnant women, beta strep, and that's treated with
12 antibiotics?

13 A. Yes.

14 Q. And that's to prevent any transfer of the
15 strep to the baby during the birth of the -- of the
16 fetus?

17 A. Well, except in this case where her water was
18 broken. So she had lost before she came to St. Mary's
19 her -- She was at risk for intrauterine infection
20 because one of the natural barriers to prevent an
21 infection of her baby wasn't in place. Her amniotic sac
22 had been ruptured. And that put her at much greater
23 risk of having a baby that was going to be harmed by any
24 infection that could have occurred in the vagina.

25 Q. Put her at risk. But just because someone is

1 at risk doesn't mean it's going to happen, correct?

2 A. That's correct.

3 Q. Okay. And, in fact, there was a surgical
4 pathology performed on Heather McCants' placenta after
5 birth; do you recall that?

6 A. Yes.

7 Q. Okay. I'm going to hand you this document,
8 which I'm going to mark as Plaintiff's Exhibit
9 Number 24.

10 (Plaintiff's Exhibit Number 24 was marked for
11 identification.)

12 BY MR. SILVA:

13 Q. And what were the results of that pathological
14 review of her placenta after birth?

15 A. Under the final diagnosis it said early third
16 trimester placenta with a three vessel umbilical cord
17 showing no specific histopathologic alteration.

18 Q. Okay. Is there a diagnosis of
19 chorioamnionitis on that form?

20 A. No.

21 Q. Okay. What is chorioamnionitis?

22 A. It's an infection of the membranes of the
23 gestational sac.

24 Q. Okay. You also mentioned that she had a
25 positive AFP?

1 A. Yes.

2 Q. Okay. What does AFP stand for?

3 A. Alpha-fetoprotein test.

4 Q. Okay. What is that test performed for?

5 A. The presence of an extra amount of a protein
6 product in the mother's circulatory system that could
7 signal one of many problems with the baby.

8 One of the problems might be an opening or a
9 hole in the baby's spine. That's called spina bifida.
10 That can cause the release of the alpha-fetoprotein from
11 the baby's system to the amniotic fluid through the
12 placenta into the mother's system. That's one
13 possibility.

14 Q. You're talking about a neural tube defect?

15 A. That's correct.

16 Q. Did this baby have a neural tube defect?

17 A. I did not follow up on all the problems that
18 this baby had. This baby had a lot of problems. But --
19 but I don't know --

20 Q. Do you know if this baby had a neural tube
21 defect?

22 A. I do not know. And there are other people
23 that can speak to what the baby had. But I do not know
24 that it did.

25 Q. Do you know as you sit here today if this

1 child has a diagnosis of spina bifida?

2 A. I -- I do not know.

3 Q. Okay. Now, Mr. Mittelmark asked you a long
4 line of questioning about when Heather McCants came into
5 this hospital, St. Mary's, her baby's health continued
6 to do well in the womb prior to the Cathflo incident; do
7 you agree with that?

8 A. To -- to -- Well, only to the degree that a
9 biophysical profile shows that the baby is stable. It
10 doesn't -- doesn't take into account that the membranes
11 have been ruptured. It doesn't take into account that
12 the mother had been carrying a bacteria infection in the
13 vagina. It doesn't take into account that the mother
14 had a white count of 30,000 before she was transferred.
15 It doesn't take into account that this -- this mother's
16 alpha-fetoprotein test, which not only looks for neural
17 tube defects, but is also a marker for something wrong
18 with the baby.

19 And, you know, from your presentation, I
20 understand that the baby has a very small head and some
21 other problems that it can be a marker for. So as I
22 understand it this is -- this is a baby that, yes, the
23 biophysical profiles were eight out of eight. They are
24 not perfect for every single scenario: It doesn't talk
25 about the amniotic fluid; it doesn't talk about

1 infection; it doesn't talk about positive AFP; it
2 doesn't talk about prematurity and the immature brain,
3 lungs and digestive system. So as -- as a test within
4 its limitations, it was fine.

5 Q. So all of the biophysical profiles were
6 normal. I think you counted 12 or 13?

7 A. I don't recall the exact number, but we could
8 recount them.

9 Q. That's fine. Twelve or thirteen, they were
10 all normal?

11 A. They were all eight out of eight, correct.

12 Q. Okay. Eight out of eight is a perfect score,
13 isn't it?

14 A. For what it's limited scope of evaluation,
15 yes.

16 Q. Is there anything based upon the biophysical
17 profile -- all the biophysical profiles prior to the
18 Cathflo incident in this case that led you to conclude
19 that you needed to deliver this baby early?

20 A. No.

21 Q. Did you conclude that this child needed to be
22 delivered early because the mother had chorioamnionitis?

23 A. No.

24 Q. Did you conclude that this baby needed to be
25 delivered early because there was a maternal infection?

1 A. No.

2 Q. Did you conclude that this baby needed to be
3 delivered early because the mother had a high heart
4 rate?

5 A. Yes.

6 Q. Prior to the Cathflo --

7 A. Oh, no. I'm sorry.

8 Q. -- incident. Yeah.

9 A. I'm sorry.

10 Q. Okay. So prior to the Cathflo incident, you
11 never concluded that this mother needed to have her baby
12 delivered because she had a high heart rate, correct?

13 A. Correct.

14 Q. Did you conclude that the mother,
15 Heather McCants, needed to have her baby delivered early
16 prior to the Cathflo incident because she had a positive
17 alpha-fetoprotein?

18 A. No.

19 Q. I think that Mr. Mittelmark did a very good
20 job of pointing out that approximately one hour prior to
21 the Cathflo incident this child had a biophysical
22 profile that was eight out of eight, correct?

23 A. Yes.

24 Q. And that was performed by Dr. Tum?

25 A. It was ordered by -- Probably I think the

1 original order may have originated with Dr. --
2 Dr. Stoessel. The performance of the test is by an
3 ultrasonographer. And it was inter -- it was then
4 interpreted by a radiologist, and the report was
5 generated.

6 Q. Okay. And that biophysical profile
7 approximately one hour prior to the Cathflo incident on
8 January 26, 2011 was normal, or eight out of eight?

9 A. Correct. So that -- that criteria of a
10 potential trigger for delivery did not indicate delivery
11 had to happen.

12 Q. And that's my next question. Based upon your
13 experience as a board certified OB/GYN -- How many years
14 have you been practicing?

15 A. I've been in private practice since 1987.

16 Q. 1987. Since -- You've been in practice since
17 1987, how many babies or fetuses have you taken care of
18 where the mother had premature ruptured membranes?

19 A. Hundreds.

20 Q. Hundreds. And what is your goal when a mother
21 has a premature ruptured membrane with regards to how
22 long you want to have the baby stay in the womb?

23 A. That's a complex answer. Let me start it this
24 way: Depending on how far along the pregnancy is, there
25 are certain goals that you have. You want to -- You

1 have to first take into consideration the status of the
2 mother. If the mother -- if the mother dies, the baby
3 dies. Okay?

4 So if the mother's life is at risk because
5 she's had cardiopulmonary arrest or she's had a car
6 accident and she's bleeding profusely, you have to
7 deliver the baby if it's viable no matter what. You
8 can't -- You know, you got to deliver, when you got to
9 deliver in those -- in that type of an emergency.

10 Then you have those situations where the
11 mother has medical problems: Maybe she's a diabetic;
12 maybe she failed a sugar test; maybe she has high blood
13 pressure; maybe her heart runs fast; maybe she's big;
14 maybe she's obese; maybe she's morbidly obese; maybe she
15 has other medical problems.

16 You want to stabilize those as much as you can
17 so that the atmosphere where the baby's growing is -- is
18 stable.

19 Now as to the baby, the baby is another unit.
20 You know, is the bag of water broken or not broken. If
21 it's broken, you look for signs of infection. If the
22 baby is early, premature, you want -- you want to help
23 accelerate the development of the brain, the lungs and
24 the intestines for as long as you can.

25 Now, there is some medicines we can give while

1 the baby is still inside like steroids, dexamethasone or
2 betamethasone to allow the baby to have a better chance
3 of its lungs working.

4 There's some medications that -- like
5 antibiotics that if the baby might be exposed to an
6 infected environment that the antibiotics will kill the
7 bacteria to the point where you can't see it by looking
8 at a piece of the placenta. You're going to keep an eye
9 on the mother again to make sure she doesn't have a
10 fever or uterine tenderness.

11 But you want to get the baby as big as you can
12 get it before it has to be delivered either vaginally or
13 by C-section.

14 Q. Okay.

15 MR PUYA: Excuse me. I don't mean to
16 interrupt you. I've got a 1:30 hearing. Can we
17 take a five minute, ten minute break? I've got a
18 status conference with the judge.

19 MR. SILVA: Oh, yeah. You can do it by phone?

20 MR PUYA: Yeah. He's going to let me do it by
21 phone --

22 MR. SILVA: Okay. Sure.

23 MR PUYA: -- next door.

24 MR. SILVA: So a five minute break?

25 MR PUYA: Well, it's 1:26. So I think it's a

1 ten minute case management conference so...

2 THE VIDEOGRAPHER: Off the video record 1:26.

3 (A recess was taken.)

4 MR. SILVA: We have been instructed to
5 continue without Mr. Puya.

6 THE VIDEOGRAPHER: We're now back on the video
7 record at 1:48.

8 BY MR. SILVA:

9 Q. Doctor, you're not an anesthesiologist, are
10 you?

11 A. No.

12 Q. You're not a board certified anesthesiologist?

13 A. No.

14 Q. You're not board certified in neuroradiology?

15 A. No.

16 Q. How about rehabilitation medicine?

17 A. No.

18 Q. Are you board certified as a geneticist?

19 A. No.

20 Q. Now, you mentioned earlier AFP. Besides a
21 neural tube defect, what else can that indicate?

22 A. It can indicate -- It has been noted to be a
23 marker of adverse perinatal outcomes.

24 Q. What does that mean?

25 A. Including preterm ruptured membranes. You

1 know a test that if it comes out positive, you know, you
2 look for the things that it's the most sensitive and
3 specific to. For example, you do a level 2 ultrasound
4 to see if you can detect a large or a medium sized
5 neural tube defect. But it's not going to -- You know,
6 an ultrasound isn't going to catch a small neural tube
7 defect.

8 But that pregnancy is a high-risk pregnancy if
9 you have a positive alpha-fetoprotein test. It could
10 also be a marker for unusual chromosomal abnormalities
11 and unusual morphological abnormalities of a real small
12 head or small neck and shoulders.

13 Q. What else?

14 A. Well, the list is exhaustive. I'm sure some
15 expert will be telling you the what else later.

16 Q. Have you ever done any type of research on
17 what an abnormal AFP result can result in?

18 A. Only to satisfy my own curiosity, not
19 related -- not in regards to this case.

20 Q. In your practice what do you use AFP for?

21 A. Well, we do it as a screen for neural tube
22 defects, premature labor and as a marker for high-risk
23 pregnancies.

24 Q. Okay. Did this mother have premature labor?

25 A. Yes.

1 Q. She was in labor?

2 A. She had contractions, yes.

3 Q. Where?

4 A. I believe in Indian River. That's one of the
5 reasons they sent her. Her white count was 30,000. She
6 was hydrated. I mean not -- Did she dilate and progress
7 in labor, no.

8 Q. What's the definition of labor?

9 A. Progressive cervical dilation and effacement.

10 Q. Was this woman in labor when she arrived at
11 St. Mary's Medical Center?

12 A. No, she was not.

13 Q. Okay. So as far as you know, Ms. McCants was
14 never in labor at St. Mary's Medical Center, correct?

15 A. Correct.

16 Q. And I think you've already told us you don't
17 know if this child has ever had a diagnosis of a neural
18 tube defect after birth, do you?

19 A. No.

20 Q. Now, if this child didn't have the Cathflo
21 incident that required the delivery at 27 weeks, ideally
22 how long would you have wanted this child to stay in the
23 womb?

24 A. I guess the general answer is as long as
25 possible all other things being normal.

1 Q. Okay. But let's -- let's assume that she was
2 continuing to be monitored in the hospital. Would you
3 have allowed -- allowed her baby to mature to 38 weeks
4 of gestation, or would have taken him -- taken him by
5 C-section prior to that?

6 MR. MITTELMARK: Objection to the form.

7 THE WITNESS: In general because of the stress
8 of the preterm ruptured membranes, the fetal lung
9 maturity was accelerated, the standard for a normal
10 pregnancy would be you would do a repeat C-section
11 at 39 weeks.

12 And patients with preterm ruptured membranes,
13 we would actually collect fluid from the mother, if
14 fluid was available to be gotten then either by
15 amniocentesis or by -- by collection, having her
16 sit on a bedpan and letting amniotic fluid fall
17 out.

18 And when maturity was recognized. So it could
19 have been as early as 35 weeks, or it could be as
20 late as 39 weeks.

21 BY MR. SILVA:

22 Q. Okay. Would you -- In a patient who has
23 premature ruptured membranes and has no other indication
24 for an earlier C-section, is there any time that you
25 would take a baby before 35 weeks?

1 A. Yes. Sometimes, you know, when they get
2 four-and-a-half pounds. Sometimes if there are other
3 maternal or fetal indications for involvement.

4 Q. Okay.

5 A. If it's not growing, you know, like gaining
6 weight by ultrasounds. If it's not -- If other markers
7 of -- of well-being aren't met.

8 Q. If Heather McCants had continued to remain
9 stable, would you have kept her in the hospital or would
10 you have sent her home?

11 A. No. She would have remained hospitalized till
12 delivery.

13 Q. Okay. Even if her alpha-fetoprotein, AFI
14 increased?

15 A. Okay. They're two different things. AFI is
16 amniotic fluid index to me.

17 Q. That's what I meant, AFI.

18 A. All right. If the -- If it appeared that the
19 mother sealed and was no longer leaking and the amniotic
20 fluid was in the normal range, under certain
21 circumstances patients could be released.

22 The specific problem with where Ms. McCants
23 lived and worked was that the nearest Level 3 hospital
24 was St. Mary's, and it's quite a ways away. So, you
25 know, you have to balance the risk and the benefits of

1 early premature discharge or the consequences of a
2 delivery requiring transport of a premature baby.

3 Q. Okay.

4 A. So some discussion and some calculus has to be
5 made in terms of what's best for the baby and the
6 mother.

7 Q. What kind of an AFI would you look for, for
8 example, in Heather McCants before you would say, okay,
9 I'm going to release her let's say to a family member's
10 house in West Palm Beach?

11 A. Well, in some places if it was say more than
12 ten consistently for a long period of time and no
13 evidence of infection.

14 Q. So your plan on this patient prior to the
15 Cathflo incident that caused changes with the mother and
16 the baby was to continue to monitor her in the hospital
17 until the time that the baby could be safely delivered?

18 A. Correct. Had clinical evidence of fetal lung
19 maturity, weight of greater than four-and-a-half pounds,
20 the absence of other indicators for delivering.

21 Q. How would you determine this fetus's clinical
22 lung maturity?

23 A. By obtaining a sample of amniotic fluid either
24 by amniocentesis, which is where we stick the needle
25 into the intrauterine cavity and extract it or by

1 collection by having the mother sit on a bedpan and
2 allow amniotic fluid to be collected and submitted for
3 evaluation.

4 Q. Okay. And when -- when you take that sample
5 of amniotic fluid say from the bedpan, what kind of test
6 do you run on it to determine the fetal lung maturity?

7 A. L/S and -- L/S ratio and PG. Although at some
8 point we rolled over into something called laminar body
9 studies, which is a product -- a protein product that is
10 in a sufficient quantity in babies whose lungs are
11 mature.

12 Q. That's the laminar body studies?

13 A. Correct.

14 Q. And is that a routine test that you can
15 perform at the hospital at St. Mary's?

16 A. Yes. I mean I can't speak to whether it's
17 actually performed at the hospital or sent out to a
18 reference lab.

19 Q. Right. But you can order it at the hospital?

20 A. You can order it. Yes, it's something we do
21 often.

22 Q. Did you guys ever order a laminar body
23 study --

24 A. No.

25 Q. -- prior to the Cathflo incident?

1 A. No.

2 Q. Do you have any expert opinions as an
3 anesthesiologist for the care rendered by Dr. Lane?

4 A. No.

5 Q. What would you have done differently as far as
6 monitoring Heather McCants' baby if she continued in the
7 hospital prior to the Cathflo incident that required her
8 early delivery?

9 MR. MITTELMARK: Object to the form.

10 BY MR. SILVA:

11 Q. You can answer.

12 A. I'm not sure I completely understand what
13 you're asking.

14 Q. Yeah. Well, you agree that the reason that
15 this baby was delivered at 27 weeks is because she had a
16 reaction to Cathflo, the mother and the baby had a
17 reaction to that incident, to that event?

18 A. Do I agree with that? I think the mother had
19 persistent maternal tachycardia in the 160s and 150s the
20 basis of which was not clear.

21 It happened acutely on the same day that she
22 had a reaction to Cathflo in proximity to a reaction to
23 Cathflo.

24 The baby, on the other hand, had a
25 deceleration that could be explained in many different

1 ways but appeared to be recovering so...

2 Q. And is that the reason that you did the
3 C-section?

4 A. Yes.

5 Q. Okay. Now, if the mother's heart rate was 125
6 knowing that she had a history of tachycardia, would you
7 have performed a C-section based upon that information
8 alone?

9 A. No.

10 Q. I'm going to hand you Plaintiff's Exhibit
11 Number 12, which is the Rapid Response Team Worksheet.

12 Can you tell me what the mother's heart rate
13 was recorded at?

14 A. 125.

15 Q. Okay. Knowing what you knew about
16 Heather McCants and her history of tachycardia, would
17 you have performed a C-section on her that day on
18 January 26, 2011 for a heart rate of 125?

19 MR. MITTELMARK: Object to the form.

20 MS. WIDLANSKY: Form.

21 MR. PUYA: Join.

22 THE WITNESS: Without an evaluation, no.

23 Evaluation for fever, for infection, or would have
24 had an internal medicine consult to take a look to
25 see what the possible causes were.

1 But, obviously, it deteriorated from 125 to
2 the 150s to 160s, which is dramatic. It was
3 already abnormal. Now its going to be, like I
4 said, twice normal.

5 BY MR. SILVA:

6 Q. Well, didn't you order the -- the C-section at
7 the time of the Rapid Response Team call?

8 A. I ordered preparation for a C-section, yes.

9 Q. Okay. That's when you ordered the C-section,
10 right?

11 A. That's when I ordered the preparation for
12 C-section, correct.

13 Q. Okay. And what was Heather McCants' heart
14 rate at that time?

15 A. Well, it depends. You're just pointing to --

16 Q. Take a look at the documents.

17 A. Yeah, I see that. But there was -- There were
18 more measurements. You know, what you're negating is
19 whatever information Nurse Duckworth presented to me at
20 the time of the phone call, which was after this.

21 Q. There are more measurements. There's actually
22 a strip there. Tell us what her heart rate was there.

23 A. There's a strip here. Okay.

24 Q. Tell us what the heart rate was on the strip.

25 A. 116.

1 Q. Okay. It was actually lower than 125, wasn't
2 it?

3 A. When the strip was run, yes.

4 Q. Okay. When was that strip run?

5 A. I can't exactly read the time, but I'll be
6 open to -- If you could point to me a legible time.

7 Q. Yeah. Let me take a look.

8 I don't see a time.

9 A. Okay.

10 Q. Is this strip attached to the Rapid Response
11 Team Worksheet?

12 A. Yes.

13 Q. Okay. And what is the maternal heart rate on
14 that strip?

15 MS. WIDLANSKY: Form.

16 THE WITNESS: 116.

17 BY MR. SILVA:

18 Q. Okay. Did you base your decision to perform a
19 C-section on Heather McCants on January 26, 2011 based
20 upon the heart rate of 116 --

21 MS. WIDLANSKY: Form.

22 THE WITNESS: No.

23 BY MR. SILVA:

24 Q. -- alone?

25 A. I based it on an increase from 116 to 125 to

1 129 at 1519 to 150 and 160 sometime thereafter.

2 Q. Well, by the time it was 150 and 160, you had
3 already called a C-section, right?

4 A. Yes. Preparation for C-section, correct.

5 Q. Preparation for C-section means you called a
6 C-section, didn't you?

7 A. Preparation for C-section is preparation for a
8 cesarean section.

9 Q. Okay. And you told the nurses, and the nurses
10 advised the rest of the operating room staff to prepare
11 the patient for C-section --

12 A. Correct.

13 Q. -- correct?

14 And you performed that C-section?

15 A. I did because she -- her heart rate was even
16 higher.

17 Q. Right.

18 A. And that indicated to me a deteriorating
19 maternal status. Like I said, if I didn't inter -- if I
20 didn't intervene, would we be -- would we be here today
21 talking about a totally different problem this time with
22 Ms. McCants?

23 Q. Well, you had to do what you did to intervene,
24 didn't you?

25 A. Yes, and I did.

1 Q. Okay. You did your job, right?

2 A. Yes.

3 Q. Now, I want you to show me where in the
4 medical records the mother's heart rate is -- prior to
5 her C-section where it is 160. Prior to the C-section.

6 A. In the anesthesia record?

7 Q. In the anesthesia record.

8 A. Uh-huh.

9 Q. Yes.

10 A. That's prior to her C-section. She has the
11 spinal in, and the heart rate graph looks something that
12 if she were a car, she'd be running twice normal rate.

13 Q. Twice normal rate. What was her normal rate,
14 120?

15 MS. WIDLANSKY: Form.

16 THE WITNESS: What day?

17 BY MR. SILVA:

18 Q. What was her normal heart rate?

19 A. What day?

20 Q. How about on -- when she was admitted?

21 A. Okay. I have a heart rate of 116, a heart
22 rate of 112, a heart rate of 93, a heart rate of 90.
23 I'm just going to give these to you.

24 Let's make this an exhibit.

25 Q. No, you don't get to mark exhibits.

1 A. Oh, I don't? Okay. Well, then here. Let me
2 give it to you.

3 Q. Unless you want to go to law school.

4 A. No, sir. I just want you to get this
5 information as quickly as possible.

6 Q. Just tell me.

7 A. Well, it's recorded as vital signs. The 17th
8 of January at 1730 it's record as 116. But on
9 January --

10 Q. 116?

11 A. Yeah. January the 18th it's 90 and 93.

12 Q. Okay. So 116 times two, what is that?

13 A. Sir --

14 Q. 240?

15 A. Yeah.

16 Q. You're telling me that her heart rate was
17 twice her normal heart rate, and that's the reason that
18 you did the C-section.

19 Was her heart rate ever 240 anywhere in these
20 medical records? Show me where her heart rate was 240.

21 A. No.

22 MS. WIDLANSKY: Form.

23 BY MR. SILVA:

24 Q. Can you show me that?

25 A. No. I said twice normal, not twice her rate.

1 So you're confusing two things.

2 Q. Well, what's -- what's her normal rate?

3 (Mr. Puya entered the room.)

4 THE WITNESS: Well, like I said, one day
5 here --

6 BY MR. SILVA:

7 Q. We're not talking about some fantasy patient.
8 We're talking about Heather McCants.

9 A. Right.

10 MS. WIDLANSKY: Form.

11 MR. BLOOM: Join.

12 BY MR. SILVA:

13 Q. What's her normal heart rate?

14 A. Well, what date do you want it to be? What
15 date do you want me to tell you her pulse, and I will
16 tell you.

17 Q. Didn't you tell me it was 116 on her
18 admission --

19 A. Yes.

20 Q. -- one of the readings?

21 A. Yes, on one reading.

22 Q. Okay. Did you discount that reading, or do
23 you think it was falsely entered by the -- by the
24 nurses?

25 MR. MITTELMARK: Object to the form.

1 MS. WIDLANSKY: Form.

2 MR PUYA: Form.

3 THE WITNESS: I'm sorry. Could you repeat
4 that question?

5 BY MR. SILVA:

6 Q. Did you discount the reading of 116 beats per
7 minute on admission, or did you think that was falsely
8 entered by the nurses?

9 MR. MITTELMARK: Object to the form.

10 MS. WIDLANSKY: Join.

11 MR PUYA: Join.

12 THE WITNESS: Neither.

13 BY MR. SILVA:

14 Q. Now, once you told me, just a few minutes ago,
15 that one of the other reasons that you decided to do the
16 C-section on Heather McCants is because she had a heart
17 rate in the 160s in the operating room; is that what you
18 said?

19 A. And I'm going to point that to you if I may.

20 Q. I would like you to.

21 A. Okay. Let me see Plaintiff's exhibits --

22 Q. Are you looking at -- for the anesthesia
23 record?

24 A. Yeah.

25 Q. Okay. Here it is.

1 A. Here we go.

2 Q. It's Plaintiff's Exhibit Number 19.

3 A. Okay.

4 Q. Tell us what the patient's heart rate was on
5 that form.

6 A. 160. 160. Looks like a couple 160s. 155
7 maybe.

8 Q. Do you see a vital sign entry there on that
9 anesthesia note?

10 A. I see many of them.

11 Q. Look at the vital sign entry.

12 A. Okay. Let's make sure we're both looking at
13 the same thing.

14 Q. Yeah.

15 A. You're talking about here where it says pulse
16 129?

17 Q. Well, does this say pulse 129?

18 A. That's what it says.

19 Q. Right?

20 A. Yes.

21 Q. Okay.

22 A. Which is different than one oh -- 100, and
23 it's different than 116.

24 Q. And it's all --

25 A. But -- And we can agree --

1 Q. It's different.

2 A. -- that all the pulses here are higher than or
3 equal to 150.

4 Q. And it's different from 160, isn't it?

5 A. And it's different from what she had on the
6 17th the through one hun -- through -- Wow, even after
7 her surgery.

8 Q. Are you looking at these check marks here?

9 A. No. I'm looking at the dots. It's the dots
10 that are pulse.

11 Q. You know that that is her blood pressure,
12 right?

13 MS. WIDLANSKY: Form.

14 THE WITNESS: Yes. Yeah. But do you see
15 these dots?

16 BY MR. SILVA:

17 Q. Do you know how to read an anesthesia record?

18 A. Yes.

19 Q. Are you an anesthesiologist?

20 A. No.

21 Q. Okay.

22 A. No. I'm an experienced OB/GYN that reads a
23 lot of records.

24 Q. Okay. And do you disagree that the pulse as
25 noted on the vital sign portion there is 29?

1 A. No. And it's abnormal.

2 Q. You agree with that, right?

3 A. That's what it says.

4 Q. Okay. And didn't you look at the pulse on
5 admission and just tell me a little while ago that it
6 was 116?

7 A. Yes.

8 Q. Do you consider the difference between 116 and
9 129 statistically different -- significant?

10 A. In a patient who had acute shortness of
11 breath, and let me see what else was recorded on your --
12 on that note that we were talking about.

13 I mean you're not asking me to ignore it, are
14 you? I mean I certainly wouldn't ignore it, because
15 then I would be -- like I said, we'd be here for a
16 totally different problem.

17 Q. I'm ask -- I'm asking you do you a consider a
18 pulse on admission of 116 and then a pulse of 129 in the
19 operating room statistically significant?

20 A. Yes.

21 Q. This difference?

22 A. Yes, because --

23 Q. You do?

24 A. Yes. Because not just on the pulse alone,
25 because I'm not treating a pulse. I'm treating a human

1 being.

2 And the pulse is one of many measures. And if
3 you take the history of what this patient I was told had
4 happened, and which you pointed out, on January 26th at
5 1516 the rapid response note page two says the patient
6 had shortness of breathe with chest pain.

7 Now, you're not asking me to ignore that, are
8 you?

9 Q. Are you looking at --

10 A. And -- Listen.

11 Q. Do you have --

12 A. And --

13 Q. Are you asking me a question?

14 A. No, I'm telling you the answer. The answer is
15 I'm treating --

16 Q. What's -- What was my question?

17 MS. WIDLANSKY: Let him --

18 BY MR. SILVA:

19 Q. What was my question?

20 A. Go ahead and please read the question.

21 MS. WIDLANSKY: Let's him finish.

22 BY MR. SILVA:

23 Q. You don't -- you don't get to make a speech.
24 You have to answer my questions.

25 MS. WIDLANSKY: He is answering your question.

1 You're interrupting him.

2 MR. SILVA: Repeat the question so he
3 understands what he has to answer.

4 (The question was read by the reporter.)

5 MR. SILVA: Statistically significant.

6 THE WITNESS: Different, yes.

7 BY MR. SILVA:

8 Q. Thank you. Now, you testified earlier the
9 reason that you decided to perform this C-section is
10 because Heather McCants had an abnormally -- she was at
11 a very high rate, twice her -- the double heart rate,
12 and that's the reason you needed to perform the
13 C-section.

14 And do you recall just going over her heart
15 rate on admission being 116, and in the operating room
16 being 129; do you recall that?

17 A. You have mischaracterized what I stated. You
18 can ask the court reporter to repeat my answer. Her
19 pulse was twice that of a normal person.

20 It is still a significant change from her own
21 baseline. And if you take into consideration her
22 clinical picture if we are to believe the rapid response
23 where she had chest pain and shortness of breath and now
24 has tachycardia more than her usual, a prudent physician
25 would evaluate this patient for a pulmonary embolism.

1 Q. Do you know if the person who decided that she
2 had tachycardia knew that she had a history of
3 tachycardia prior to admission at St. Mary's?

4 A. Yes, that was me.

5 Q. That was you?

6 A. Right.

7 Q. Okay.

8 A. And it's recorded in my history and physical.

9 Q. And you considered -- Did you consider the
10 baby to have tachycardia, fetal tachycardia?

11 A. When?

12 Q. At any point in time prior to the delivery?

13 A. Any time there is greater than 160, yes.

14 Q. Okay. So you also thought that the baby had
15 tachycardia?

16 A. I didn't think that. I knew that.

17 Q. Okay. Did the baby have a heart rate double
18 what you would expect in a baby?

19 A. Now you're saying things and testimony that
20 I've never said.

21 Q. No. I'm asking you. It's a question.

22 A. Yeah. The question is I don't know what you
23 mean by that.

24 Q. Did --

25 A. Where did you -- where did you get the idea

1 that that was said?

2 Q. Did you think -- I'm asking you do you think
3 that the baby had a heart rate twice the normal heart
4 rate when you said the baby had fetal tachycardia?

5 Do you understand my question?

6 A. No. Repeat it.

7 MR. SILVA: Okay. Repeat it court reporter.

8 (The question was read by the reporter.)

9 THE WITNESS: No.

10 BY MR. SILVA:

11 Q. No what?

12 A. No, I don't understand your question. A
13 normal fetal heart rate can be as high as 160.

14 Q. Okay. Can -- can a fetal heart rate ever be
15 240?

16 A. Yes.

17 Q. Can it be 280?

18 A. Yes.

19 Q. Okay. Did this baby have an fetal heart rate
20 of 240?

21 A. No.

22 Q. Did this baby have a fetal heart rate of 280?

23 A. No.

24 THE VIDEOGRAPHER: We need to go off record to
25 change tape real fast.

1 MR. SILVA: Okay. Go ahead.

2 THE VIDEOGRAPHER: Off the video record at
3 2:13.

4 (A recess was taken, and the proceedings were
5 continued in Volume II.)

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